THE CANADIAN NURSE

L'Infirmière canadienne

VOLUME 52 NUMBER 12
MONTREAL

DECEMBER 1956

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THE CANADIAN NURSE

L'Infirmière Canadienne

VOLUME 52 **NUMBER 12**

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Editor and Business Manager
MARGARET E. KERR, M.A., R.N.

Assistant Editor
JEAN E. MacGREGOR, B.N., R.N.

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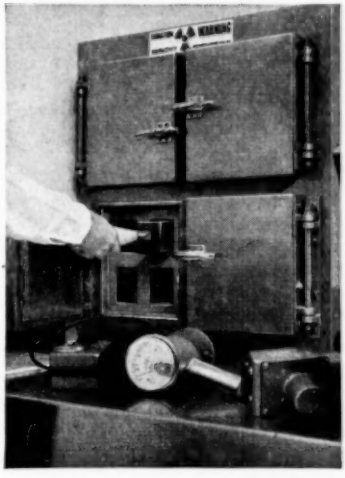

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966

"from Contented Cows"

Between Ourselves

We heartily welcome **Helen G. McArthur** as our guest editor this month. The national director of nursing service with the Canadian Red Cross Society spent Christmas 1954 in Korea where, for nearly eighteen months, she served as liaison and coordinator, guiding the newly organized Korean Red Cross in its first eager steps. Since her return to Canada just a year ago, Miss McArthur has filled a seemingly endless round of speaking engagements. Thousands of Canadian nurses have been enthralled by her vivid word pictures as well as interested in the hundreds of actual photographs that she took.

Our cover picture is from one of Miss McArthur's negatives. A short time before Christmas, 1954, a consignment of hot water bottles and warm bathrobes was shipped by the Canadian Junior Red Cross to Korea for the children who were patients at the Inchon Sanatorium. The big bundles arrived at the time of the first heavy snowfall and the gifts were distributed to the children as part of their Christmas. For a small, tuberculous child, a cuddly bathrobe and his own hot water bottle to tuck into bed with him at night, were welcome gifts indeed.

* * *

Volume 52 closes with this issue. Early in the new year, the **Index** of all of the material that has been published during 1956 will be ready. Several years ago the policy was established of including request coupons in the December and January issues so that any nurse desiring to have a copy of the Index might ask to have one sent to her. If you turn to page 943 you will find the coupon. There is no charge for the Index. Please send in your order early so that we may have some guide regarding the number of copies that will be needed. Schools of nursing, university and public libraries automatically are mailed copies of the Index so no request is necessary.

* * *

How does a student nurse react to the new and different environment of the pediatric department in a large general hospital or to affiliation in a separate children's hospital? What problems do parents face when they have to take their child to hospital? Apart from the care of his physical discomfort and disability, what different kind of handling does the child patient require?

These and numerous other aspects of **pediatric nursing** formed the topics for discussion at a special conference convened by the Montreal Children's Hospital. While the information each report contains is exceedingly useful the whole project has such merit that it is to be hoped comparable groups in other communities will follow the example and plan a similar kind of conference. When you do, incidentally, don't forget to share the papers with the rest of us through the pages of *The Canadian Nurse*.

* * *

Moving day for the Registered Nurses' Association of Ontario came around at the end of last month. Hereafter, all association business, including registration, membership renewals, committee meetings, etc., will be conducted in the large, comfortable accommodation that is located at **33 Price Street, Toronto 5, Ont.**

Our congratulations to the R.N.A.O. May the work of the Association thrive mightily now they are in their very own building! We hope to have a description of it to share with all our readers, as early as possible next year.

* * *

How do you like the new **type-face** we are using for our article titles? We were awfully tired of the heavy blackness of the type-face we had for several years so did a little experimenting. We think the new, thinner type an improvement, don't you?

* * *

It isn't too late to order that Christmas **gift subscription** to *The Canadian Nurse* for your young student friend. We will send a card announcing you as the donor in time for Christmas and start her subscription with the January, 1957 issue.

We have all been so accustomed to referring to student nurses as "she." With an increasing number of men in training in our schools of nursing, we should have suggested "her or his" subscription in the paragraph above. For either, the purchase price is $5.00 for a three-year subscription. Start them off for the New Year with their own professional *Journal*.

Good-bye for 1956. A Happy Christmas to all of you!

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Description—Each three-coloured tablet provides: Dextro-amphetamine sulphate 15 mg., amobarbital 100 mg.

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Indications—To provide therapeutic effects over 10 to 12 hours from one dose, in emotional instability, depressive states, nervous tension, etc.

Administration—One tablet on arising.

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Manufacturer—Abbott Laboratories, Ltd., Montreal.

Description—Each 30 cc. (fluid ounce) contains: Codeine phosphate 1/3 gr., nembutal sodium 3/8 gr. in a palatable, aromatic syrup.

Indications—A new, improved formula, flavor and color. Apricot-flavored, highly acceptable and highly effective for cough due to colds. Mucous liquefying, antispasmodic, sedative and inhibitory to the cough reflex.

Administration—Adults, 1 to 2 teaspoonfuls every 2 to 4 hours; children 6 to 10 years of age, 1 teaspoonful; children under 6 years of age, only as directed by the physician.

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Manufacturer—Charles E. Frosst & Co., Montreal.

Description—Each scored tablet contains; Colisone (prednisone) 0.5 mg., acetylsalicylic acid 325 mg.

Indications—Rheumatoid arthritis, muscular rheumatism, myositis, fibrositis, myalgia and torticollis.

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Manufacturer—Nadeau Laboratory Limited, Montreal.

Description—Each tablet contains: Desoxycholic acid 0.15 gm., homatropine methylbromide 2.5 mg.

Indications—As a choleretic, to increase hepatic activity, and as an antispasmodic.

Administration—One or two tablets, 2 or 3 times a day according to desired effect.

DENABYL

Manufacturer—J. M. Marsan & Co. Limited, Montreal.

Description—Each tablet contains: Dehydrocholic acid 300 mg., homatropin (methyl bromide) 1.5 mg., choline bitartrate 150 mg., dl.-methionine 100 mg.

Indications—Conditions due to biliary insufficiency.

Administration—One to two tablets twice daily after meals.

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Manufacturer—Carter, Cummings & Co., Ltd., Windsor.

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Indications—Relieves pain of headaches, neuralgias, neuritis, muscular aches, common cold, rheumatic and arthritic pains.

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In mild or moderate cases, suggested initial dosage is 6 tablets daily, usual maintenance dose is 3 to 4 tablets daily.

1956 INDEX

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THE CANADIAN NURSE

L'Infirmière Canadienne

A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES' ASSOCIATION

VOLUME 52 NUMBER 12

MONTREAL, DECEMBER, 1956

Christmas in Korea

As we sat, the lamps were put out and we saw again the beauty and the magic of the Nativity scene. In the soft candlelight sat Mary with the Babe in her arms, gently rocking to and fro. There was little sound excepting the restless movement of the animals that were near her until, through the door, entered first one then another — with splendor and dignity, the three Wise Men came bearing their gifts of gold, incense and myrrh. As each knelt to leave his gift at the feet of this Mother and Child, we felt again the wonder of the ancient story, reenacted in a hospital in Korea. We who watched grew rich in this inheritance of Christmas. Then Joseph rose from behind Mary and lifted up his hands in prayer over the bowed heads before him. His blessing was received with deep humility and a new understanding.

It was only when the lamps were lit again that I recognized that all the heads around me were black — that I alone was fair; that the prayer had been given by a child in the Korean language that I had failed to master in the months I had been in this strange land far from my own home; that those around me were young in heart and age — war orphans from a United Nations war — while I was old from my own struggles and the weight of their tragedy. From the side lines came the Korean nurses, confident in the new found knowledge and the resources given to them by the many from the free nations who had reached out a helping hand. These young nurses had made the tableau possible knowing the need of the children who, missing the love of their parents, must find another love — even if the gowns of the well known characters were relief blankets and towels, the incense container a broken toy. How I smiled to myself when I finally discovered that one "gift" was a mechanical toy that once had played "Four and twenty blackbirds baked in a pie," as the little blackbirds bobbed their hands through holes in a tin plate; that the restive "animals" had mischievous oriental faces under the army blankets!

The Korean nurses knew that before the children's cup of happiness would be full there must be gaiety and laughter. So in they came carrying great baskets of apples, a gift from the adult guests who had come to share the Christmas Eve with the children.

Soon the youngsters were all tucked

Gold, and Frankincense and Myrrh

into their beds as was essential in the regime of treatment for tuberculosis. The sanatorium itself had been a tangible gift of friendship from Canadian children who, through the pennies and nickles and dimes donated to the Junior Red Cross, had raised the amazing sum of $87,000 in two and a half years.

Christmas Day was spent in the atmosphere and surroundings of an army compound. There the children revelled in the gifts from absent relatives or friends who had stretched their meager incomes to the limit that something might be sent. Towards evening, I joined Canadian friends at the mission house. We talked of home — that wonderful land we all loved so much, Canada. We exchanged simple gifts from our own boxes that marvellously had produced enough to provide a laden and festive table, reminiscent of Christmas dinners at home. Afterwards, we sang the old, familiar Christmas carols until the day was done.

As we rose to return to our various billets we knew that on the morrow we must continue to face and try to do something about the great tragedies of this land, Korea. The kindly leader of this band of Canadian missionaries stepped forward and, raising his hands, blessed us, asking that strength be given to each of us to meet our tasks in the days to come.

As I stood there I knew I had learned the true meaning of Christmas the night before from the little children. There they were — children with coal black hair and slanted eyes; children who had lost their loved ones; children who were poor and ill with tuberculosis but who now were rich because they could have good nursing care. What if the care they received was being given by young, inexperienced nurses who were learning the meaning of care under indescribable hardships? Somehow, these new nurses had made it possible for those children to celebrate Christmas so that I, too, caught a glimpse of a basic truth. Good nursing is a mighty weapon in the world's struggle for "Peace on earth, goodwill toward men."

HELEN G. MCARTHUR

Happy Christmas, Everyone

A Pediatric Work Conference

MADELEINE FLANDER

INTRODUCTION

AT SOME TIME during the two or three years when a young woman is learning to care for the sick, she is likely to be taken abruptly from her familiar moorings, the adult wards in a general hospital, and moved to what must seem like a turbulent sea, the children's ward or the children's hospital. To many who are working with students in pediatric nursing, their reactions are interesting and in some instances cause concern. In the wards, there may be differences in emphasis in the care, the children may seem to have a great deal of freedom or parents may have many more privileges in visiting. Because of the children, the staff may seem more closely involved with the patients, their parents and each other. The whole atmosphere, in spite of the presence of acutely ill patients and the familiar equipment for their care and treatment, can be quite different.

The staff of the Montreal Children's Hospital became interested in the reactions and needs of affiliating student nurses. They decided to hold a conference and to invite to it the directors of nursing and of nursing education of the schools sending students for affiliation.

The general plan of the conference consisted of five short talks about the pediatric setting as seen by the doctor, the child, the parents, and the psychiatrist. These talks were followed by discussion, in small groups, upon four broad topics. It was thought that the talks and the selected topics would help to give direction to the discussions. The topics were related to the responsibilities of the nurse in the pediatric setting, concepts of the "ideal" nurse which the student nurse brings, reactions which the student may show as she understands her role, and areas for combined effort between the home and affiliating schools.

In relation to this "cooperation," it is difficult, perhaps, to see how the pediatric experience can be related to the whole progress of the student nurse with relationships to that which has preceded it and to that which will follow. The label of "specialty" and "specialized school' is widely used and planning together is probably not widely practised.

The material which follows consists of a description of the process of the conference, the addresses which were given and the conclusions which were brought from the discussion groups.

Miss Flander is Director of Nursing Education of the Montreal Children's Hospital.

Process Notes on the Work Conference

HEDLEY G. DIMOCK, M.A. ED.D.

THE PROCESS OF A WORK CONFERENCE, such as the one described in some detail in this issue, is an important dimension to consider in reconstructing the conference. Process can be best defined as the way in which things are done. How the conference is planned, how the members participate, and how they interact with one another and the conference staff are all vital questions in a consideration of process.

The work conference was organized

Dr. Dimock, the director of group guidance at the Montreal Children's Hospital was previously on the staff of the Center for Improving Group Procedures, Columbia University, New York.

by Miss Flander. It had been five years since the hospitals affiliating with the Children's had all met. Another meeting of this group was long overdue and Miss Flander felt that a work conference might be more beneficial to all than the usual series of meetings.

The objectives of this work conference were to:

1. Increase the understanding about the student nurse in her pediatric training.
2. Envisage more clearly the role of the pediatric nurse and the pediatric hospital in the community.
3. Define possible areas of cooperation between the student's home hospital and the pediatric hospital where she affiliates.
4. Facilitate an understanding and warm relationship between the Montreal Children's Hospital and the home hospitals, as well as among the home hospitals themselves.

It can be seen that achieving these four objectives depends to some extent on the way the conference is conducted and the structure within which people interact with one another. This is process and it is an integral aspect of a teaching-learning situation.

The role of process in conferences, classroom teaching, group meetings and other forms of interpersonal relations is becoming increasingly recognized and planned for in operation. What is done and how it is done go hand in hand, each depending on the other for the ultimate success of the whole. The relatively new field which explores group phenomena and how things are done in groups is called group dynamics or group psychology.

Participants

The population of work conference participants was composed of directors of nursing and of nursing education from hospitals affiliating with the Children's. In most cases both people came as the representatives of their hospital. Representatives of the Quebec, Ontario, New Brunswick, and Prince Edward Island Nurses' Associations were also present.

Plan for Process

The process of the conference was planned to help meet the specific objectives of the conference. The first objective of increasing the understanding of the student nurse in her pediatric training was planned as a series of short talks by representative members of the Children's staff. It was felt that such talks would give different perceptions of the role of the pediatric student nurse. The talks were also expected to give a structured orientation to the content of the work conference. The last three objectives were planned for through a series of informal group discussions or work groups. These groups, it was hoped, would help the members clarify and crystalize their own thinking; and also enable them to meet people in similar jobs from other hospitals. Two informal luncheons were planned which were expected to facilitate the interaction of the conference members.

Conference in Action

The conference opened with the welcoming of the members to the hospital and the conference. Several brief talks by representative members of the hospital staff followed. (The content of these talks is recorded in following pages of this issue). After the talks there was a brief question period.

The afternoon session started with the first period for work groups. These groups were organized so that no two people from the same hospital were together. Each group had a leader, a staff member from the hospital, and a recorder, who was selected from the group. There were five groups, each with about eight members. All groups discussed the same general topic — "What are the responsibilities of the nurse in the care of children?" The topic was designed to be broad enough to allow scope and flexibility in the discussions. A definite topic was assigned, however, to give some structure and direction to the conference. The topic for the following morning were: "The concepts of the ideal nurse which the student brings to the pediatric setting" and "The reactions that may occur as the student comes to understand the requirements of the pediatric setting." The topic for the third and last group discussion period was "How can the general nursing

experience and the pediatric nursing experience help the student to become happy and effective in nursing?"

Leaders and Recorders

The work group leaders were selected from the staff of the Montreal Children's Hospital. The leaders were not all from the nursing staff as they were selected for their ability to facilitate group processes rather than for their knowledge of pediatric nursing.

The leaders met before the conference and received an outline of what their function would be. The role of the group leader could be summarized as follows. The leader:

1. Helps the group to get acquainted.
2. Reports on preconference planning for the work groups.
3. Helps the group define and focus on the problem.
4. Assists the recorder and calls on her, from time to time, for summary.
5. Draws out the quiet person and keeps the dominant person from monopolizing the discussion.
6. Helps all points of view to be expressed.
7. Keeps the discussion focussed on the problem.
8. Points out the progress of the group and highlights its success.
9. Helps the group move from the abstract and the theoretical to the practical which is action orientated (something the group can do something about).

Toward the end of each session the leader called on the recorder to give a summary. Then the leader and the group helped the recorder to work up the summary for a report to the total group. This was used as closure for each work group session.

The recorders came from within the work groups and usually volunteered for the job. Different people usually took the tasks of recorder at each of the three sessions as this task severely limits person's participation. Job descriptions for the recorders were drawn up before the conference. These were passed out to the recorders at the conference. The function of the recorder was pointed out to be quite different from that of a stenographer. The recorder was described as a sort of creative listener. She was to record the main points made by the group, organize them for use by the group, and prepare them, with the group, for presentation to the whole work conference.

It was suggested that the recorder keep track of:

1. Points on which members agree.
2. Points on which there are differences of opinion.
3. Points on which she is not sure how the members feel.
4. Points mentioned but not fully discussed which the group may want to come back to later.

The recorder was instructed to seek additions and corrections to the report as it was supposed to represent the thinking of the whole group. The recorder, with the group, was expected to decide what parts of the report would be related to the whole group at the general session.

Feedback

Feedback is the process by which the individual groups share their work with the other groups which constitute the conference as a whole. At this conference three different methods of feedback were used — one at the conclusion of each of the three work group sessions. The first one is often referred to as the *group interview method*. The conference leader asks for one point or conclusion from any one of the recorders. He lists this on a blackboard or newsprint and asks if any other groups discussed this same point. He interviews each group that discussed this point and collects their ideas. Other ideas may be added from the floor. This procedure is carried on through all the major points of each of the discussion groups. Its chief advantage is that it avoids duplication of points and concludes each point before going to the next one.

The second feedback method used was *straight reporting* from each group recorder. Each recorder reviewed all the points made by her group. Again, these were listed visually so that all could follow them. This procedure allowed the recorders to demonstrate the total thinking of the group in its logical sequence.

A *panel discussion* among the recorders was the third method used.

The recorders sat together facing the group while points were listed on a board at the side of them. Contributions were discussed by all the recorders as they were brought up. At the conclusion of their discussion the meeting was thrown open to reactions by any of the participants. This method, which incidentally was preferred by the recorders, eliminated the repetition of points and still allowed for some logical development of each group's thinking. It also helped the recorder to feel more at ease. During all these feedback sessions the conference leader attempted to clarify and focus the ideas and get all points of view expressed. The record of each feedback session was mimeographed and given to the participants before the next work session.

Evaluation and Closure

In an attempt to analyze and evaluate the conference both in terms of what the participants felt they got out of it and the process used, a brief questionnaire was filled out by the participants at the last session. Here is a summary of the questionnaire, 32 participants responding.

I. On the whole I felt this conference was:
(check one)
18 — excellent
14 — good
0 — so-so
0 — poor
0 — useless

II. I felt the most successful part of the conference was:
11 — the discussion of our common problems
4 — summaries of work groups at the general feedback session
2 — the talk on the student nurse
1 — good relationship among staff at Children's hospital, all working together to make the conference successful
1 — learning how to prepare students for their pediatric affiliation

III. The most important thing I got out of the conference was:
9 — the ideas of others towards affiliates and affiliation
3 — understanding the problems in pediatric nursing
2 — the necessity of discussing problems frequently and working on them together
1 — learning newer concepts in working with children
1 — stimulation to improve patient care and student satisfaction
1 — observation of free discussion in work groups

IV. The conference might have been improved if:
13 — more time was available
3 — students had participated
2 — topics for work groups had been more clearly defined
1 — there had been more discussion from the floor
1 — more directors of nursing had been present

V. Do you feel that using the work group method was successful?
31 — yes
0 — no
Did you like this method?
31 — yes
0 — no

VI. Would you be interested in a future conference of this type?
31 — yes
0 — no

Related Readings

Benne, Kenneth and Bozidar, Muntyan. *Human Relations in Curriculum Change.* New York: Dryden, 1951.

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Adult Leadership. Vol. I No. 10 (March, 1953); Vol. II No. 1 (May, 1953); Vol. II No. 2 (June, 1953); Vol. IV No. 7 (January, 1955).

The wealth we may accumulate, the public prestige we may enjoy, the social position we may obtain, are all meaningless in the long vista of time, unless all are made to serve the cause of human dignity and freedom. What value dollars, or acclaim, or position in a world where justice, opportunity, and freedom are lost to us by force, by subversion, or by our own neglect?

— Dwight D. Eisenhower

The Pediatric Setting

ALAN ROSS, M.D.

IT IS IMPRESSIVE, INDEED, that so many from different schools and branches of the nursing field should come to talk over together problems of common interest. We are very proud of our nursing service, and have worked diligently with the nursing staff in evolving sound attitudes aimed to meet the needs of our young patients and also the needs of the undergraduate nurse.

Looking at the pediatric setting, in which we find ourselves working, from the point of view of the medical practitioner I am impressed with the fluidity of the whole scene. I feel that we are all trying harder than we did in the good old days when things were more settled; trying harder to adapt ourselves and our teaching to present needs.

There has been a dramatic change in the diseases from which our patients suffer. As the result of public health activities, immunizing campaigns and nutritional education, such conditions as typhoid fever, diphtheria and rickets are only rarely seen. Most children with pneumonia are either treated in the outpatient department or are in hospital only a few days. Infants with meningitis, even tuberculous meningitis, now recover. Diarrhea and vomiting in infancy is no longer the annual scourge that many remember so well.

Children are recovering quickly and, in most cases, completely from their acute illnesses. Unfortunately, this cannot be said for the chronic diseases, and many beds are still filled with those suffering from rheumatic fever, nephritis, congenital abnormalities and neoplasms.

A change, too, has taken place in the parents. They are still the same parents ready, in most instances, to sacrifice to the limit for their sick children. But they no longer have to accept an unpronounceable diagnosis and hope that all will turn out well in the end. Now they have many sources of information and, unhappily, misinformation. Some of this new knowledge is extremely helpful, and has made the care of the sick child much easier. Some of it has complicated the picture. In any case, this partly informed parent must be met with patience and understanding. What *Time* and the *Reader's Digest* have to say must be worked into the fabric that we are weaving around his child's illness.

The type of illness, then, is changing. Parents are expecting more than witchcraft from their doctors and nurses. However, I cannot but feel that the greatest change is taking place in ourselves and in our own attitudes. In the first place, we have come to realize that a child with cerebral palsy, for example, cannot be adequately treated by one person. The physician must be in charge but the physiotherapist, the occupational therapist, the social worker, the psychologist and the play therapist almost always have contributions to make towards good recovery. This fact has resulted in the formation of teams to study and help in a number of special illnesses of this kind. Through such a combined approach, and stimulated by our Department of Psychiatry, we are learning, too, that an illness has implications for others than the patient. It reaches out and involves indirectly the home, the patient's friends, the school, and in many instances the whole community in which he lives.

Our attitudes, then, towards a sick child, are broadening. Great changes are taking place in the problems that confront us. It is heartening to find you are aware of this changing pediatric setting, and ready to face these new problems in the nursing care of infants and children.

Dr. Ross is Physician-in-Chief of the Montreal Children's Hospital.

* * *

Comment on conferences: God needed only six days to create the world, but He had the advantage of working alone.

The Child in Hospital

JEANNE E. FAUGHNAN

THE CHILD COMING INTO HOSPITAL brings with him not only his physical and medical needs but all of his other human needs as well. His ever-demanding emotional, social and creative needs are as much a part of him here as elsewhere. To neglect trying to understand and taking steps to meet these needs may result in returning the child to his home more ill in a real though different sense than he was when he came to the hospital. Before considering how illness and hospitalization may effect the child let us look at some of the basic capabilities of children in general so that we may be better able to appreciate what these major experiences can mean to them.

The nature of a child's perceptions, the quality of his relationships, the pattern and intensity of his needs and the variety of the sources of their satisfaction differ from year to year as the child grows to adulthood. This becomes evident when we consider the varying quality of the relationship the child has with his family and friends as he grows up.

In infancy the mother is all important and the child enjoys a large measure of dependency. As he grows older he turn to his peers for support in taking on responsibilities independent of his parents. By the time the child has reached the nine to twelve-year period of his development he is experiencing a great need to be accepted by a gang of children of his own age and sex. Exclusion from it would be most distressing for him. He must feel that he is like his friends in every way to reassure himself that he is a worthy and capable human being.

The support the child gains from the knowledge that he has many close friends continues to be a need in the adolescent period of his development. Now, however, heterosexual relationships, physical appearance and popularity for its own sake become vitally important. The child at each period of his development must feel that he is achieving its goals if he is to be free from anxiety and be willing to assume the more mature attitudes and goals of the succeeding stage.

Another basic property of children, which we must understand if we are to appreciate the meaning of their experiences for them, is that they are subjective human beings. Along with their dependency goes their egocentricity causing them to perceive the happenings of their life in a subjective manner. People, things, situations may go either completely unnoticed or be greatly exaggerated depending on how the child feels about them. Thus, he sees things not as they are but according to how he feels about them.

The child has little factual knowledge against which to test his impressions. Every day strange and unexpected happenings occur as he is exposed to new experiences in the world. He cannot tell the real from the unreal. His own imaginings and the "tall tales" of others are seen as the probable since so many fantastic things apparently do occur. It is particularly difficult for a child to understand illness. His "magical" thinking and lack of knowledge of its causes and effects may be sources of great misunderstanding to him as to its true nature.

All children coming into hospital must go through a process of adjustment to the factor of illness and the experience of hospitalization with all that it implies in terms of separation from family and friends, adjustment to strange and often unpleasant procedures, the forming of new relationships and other happenings. One can make no generalizations about how a child will adjust to this event. The same situations will have different meanings for different children. The child will meet the experiences of illness and hospitalization and deal with them in terms of the strengths and weaknesses he has developed through his previous life experiences.

The child on being hospitalized be-

Miss Faughnan is assistant director, Group Guidance Department, Montreal Children's Hospital.

comes separated from his parents at a time when he needs them most. Good or bad they represent the only security he knows. His primary concern in his childhood is to be sure that they love him. He may interpret separation from them as desertion by them. This may cause him to feel that they do not think him worthy of their love which will consequently damage his feelings of personal worth. Sometimes children interpret hospitalization and illness as forms of punishment inflicted on them by the parents, especially when they have been made to feel guilty by the parents for past "mistakes."

Since the mother-child relationship is primary, especially in the early years of life, every effort should be made by the hospital staff to foster the maintenance of a close tie between the child and his home. At the same time, within the hospital, children must have a warm personal relationship with the person caring for them to feel secure. The adult responsible for their well-being must establish this relationship by offering them the love and recognition they need.

Hospitalization for the very young child or an illness that is of long-term duration for the older child can seriously impair the child's future ability to form interpersonal relationships. When the child relates to other persons he does so on a very personal level. A break in this "friendship" by the adult may be difficult for the child to understand. He may interpret it as implying a rejection of himself as a person which may cause him doubts about his own worth. It may also cause him to have serious doubts as to the trustworthiness of people in general. Should he be let down by adults in this way with any frequency he will begin to withdraw his love from such relationships and enter into them on a superficial level for the more obvious gifts and favors they can bring to him. This pattern for forming relationships may then become a basic personality trait of the child and interfere permanently with his ability to form stable and mutually satisfying friendships with other persons.

Illness and hospitalization can cause even well adjusted children to feel strange and fearful. The child may react to it by becoming outwardly aggressive in his behavior, apparently independent and able to manage his own affairs or, he may become more dependent, turn his feelings in to himself and become more anxious. It is well to remind ourselves that while the former means of expression is more apt to disturb the smooth functioning of hospital affairs the child is finding expression for his feelings and is overtly letting us know of his need for help. The latter form of expression is more apt to go unnoticed and we may not recognize the child's need for help until his anxiety overwhelms him.

The feelings children have are spontaneous. Only the form of their expression can, to some extent, be controlled. Their direct expression, either verbally or through behavior, is the most satisfactory method of releasing the tensions they create in the child. If the child feels that for some reason their expression would turn people against him he will try to suppress them which will only serve to increase his tension and eventually he will be forced to find some release for them sometimes in camouflaged or bizarre forms of behavior. A child will know that we do understand and love him when we let him know that we accept his feelings as being natural whether they be angry or friendly. We can also help him to find ways of expressing these feelings. At times he can be helped to express them verbally; at other times he will need to act them out. Adults can help the child to find socially acceptable outlets for these feelings thus providing him with tools to use for similar future experiences. However, unless the tools we offer the child provide an adequate medium for the intensity and quality of his feelings they will not provide an appropriate outlet for them.

There are many things we can do to help the child to cope with a stay in the hospital. We can make illness less of a mystery to him by giving him as many facts about it as he can understand at his age and so help him to separate the real from the unreal. If we are honest with him at all times he will learn that he can trust us. We can prepare him for each new experience so that he will know what to expect. If he believes that we will

always do this he won't have to sit in bed conjuring up horrible ideas of what we might spring on him next. We can be with the child during his trying experiences. If he already trusts us his fear will be lessened and he will be more able to endure the pain in treatment.

The child in hospital must find opportunities for self-expression and for meeting his needs. He does this on an overt level through his behavior. The major part of this behavior takes the form of what adults call play. It provides one of the most satisfactory channels for the child to express his real feelings, whatever their nature, since adults will accept many activities as play which they cannot accept when acted out in a real life situation. Thus, such truly direct expressions as kicking or biting a person, inflicting pain or expressions of anger against the restraining hospital by upsetting meal trays would not be encouraged forms of behavior but at the same time the feeling that prompts them can be recognized and accepted, and alternate forms of behavior proposed. Play activities will often serve as acceptable, alternate vehicles for such feelings and release pent-up emotions.

It is through what we call play that the child meets many of his emotional, social, intellectual-creative and physical needs. Play activities provide the tools he understands best for establishing relationships with other people. In play he investigates what things, people and situations are like and experiments in using himself in relation to them. Since play, if it really is to be play for him, is of his own making, or that of his peers or with an adult who understands him, it is always at his level of understanding and he can function in it. Thus play encourages his feelings of self-confidence and adequacy and stimulates him to think and act independently. Such thinking and acting are always to be encouraged if the child is to grow up to be a mature adult. This is particularly true in a hospital which by its very nature tends to promote feelings of dependency and regression in the child.

In his play the child re-enacts his previous life experiences at his own level of understanding. Sometimes these are pleasant happenings and he experiences again the happy feelings he had at the time of their occurrence. Sometimes they represent what the child wishes would happen and he experiences almost as much pleasure in them as though they had. At other times they are a review of unpleasant past experiences and in re-enacting them the child sifts and sorts the various components of the event and comes to have a clearer and more realistic understanding of them. He can then try out new ways of behaving himself in relation to such situations in the light of the new insights he has gained by this review of former happenings.

Too frequently it happens that adults arrange hospitals to suit their operational needs and their own standards and values. Thus, hospitals are apt to be very clean and orderly, efficiency in routines may be a major goal, quiet and "good" children may be desired. But a child-serving hospital must be a child-centred hospital. Priority must be given to providing an environment in which the child's interests are best served.

When the child trusts the people looking after him and feels secure in his environment his major concern becomes that of working towards the goals and objectives of the world which he left on coming to the hospital. He shares the standards and values of either his family or his peer group. Hospitalization and illness are seen as threatening to him as he imagines they will interfere with his place in his own world. They are seen as especially threatening to him as they affect his ability to return as an active participant to this world.

The child in hospital, certainly in the primary stages of his illness, will want to be babied and a certain amount of this will help him to feel more secure. He will test the dependability of the adults in many ways sometimes by calling them many times to see if they really care about him and if they really will come when he needs them.

However, he will soon need to have opportunities for independent thought and action, which are major necessities of healthy human beings. Let us see to it that there is a minimum of rigid rules and routines restricting the child. Let us find opportunities for children to contribute their thinking and plan-

ning for their own affairs for, while the obvious results might be the same if we do all of the planning, the child thrives on the experiences of assuming responsibility for his own behavior. Within the basic essential safety limits let us offer decision-making experiences for these children whether they revolve around group living affairs or what we refer to as the children's play.

The Student Nurse in a Pediatric Setting

HYMAN CAPLAN, M. D. *and* HEDLEY G. DIMOCK, M. A., ED. D.

MODERN ELECTRONICS could probably invent a machine that would dispense medications, chart temperatures and make beds more efficiently than nurses. Though such a robot could do many things it could not begin to be a good nurse in terms of taking care of all the needs of the patient. Even a "poor" nurse establishes some relationship with the patient and makes some contribution to his emotional and social needs. Modern nursing is essentially a human interpersonal relationship. The emphasis is on the *interpersonal.* The techniques, duties, and routines are merely the vehicles of this interpersonal contact.

Let us examine some of the varied aspects of the interpersonal relations of the student nurse in the pediatric ward in order to get a more accurate picture of her role and problems.

Nursing children is often more challenging and difficult than nursing adults. Close contact with a child for any length of time brings out the personality strengths and weaknesses inherent but often camouflaged in adult relationships. The nurse sees the child and his family under crucial situations and the interplay frequently reveals problems that may be related to her own childhood or her own family. These feelings may not be lightly dismissed, but must be understood and dealt with appropriately.

These most basic attitudes on the part of the nurse set the atmosphere for the hospital ward. The ward climate is a very important factor in the treatment of a sick child. The child senses this climate and responds to it. The parent, too, is influenced by this ward atmosphere and the security it emanates will be of marked importance in allaying the mother's fears over hospitalization, separation and so forth, and may make her less demanding and troublesome to the nurses and doctors.

A student nurse coming into a pediatric ward for the first time is faced with the following problems:

1. Learning relevant information:
   a. Facts, routine, skills and so forth, relating to the physical conditions of the patients.
   b. Information regarding the emotional and social needs and development of children.
2. The interpersonal process:
   a. Relationship with the doctor in charge.
   b. Relationships to the head nurse, supervisors, instructors, and other staff.
   c. Relationships to other student nurses.
   d. Relationships with the patients and their families.

We will attempt to touch only on basic information regarding personality growth and development and the interpersonal process.

One approach to understanding personality can be termed the "developmental need" theory. It sees children striving to meet certain needs. The first need of the child is to develop a sense of *trust.* This trust is usually found in the warm relationship with the mother. After this security has been found and the child feels he can depend on it, he attempts to es-

Dr. Caplan is assistant director, Department of Psychiatry, and Dr. Dimock is director, Department of Group Guidance, Montreal Children's Hospital.

tablish his independence as an individual. This is a need for a sense of *autonomy*. Around four years of age children strive to accomplish things and to be creative. They want to get out into the world and see what they can do. These children are said to be developing a sense of *initiative*. When children are unable to satisfy these needs they will continue to seek their satisfaction into adult life. The satisfaction of these needs — trust, autonomy and initiative — are a prerequisite to a healthy personality.

Healthy personality can also be viewed as a kind of dynamic equilibrium state in which many forces are delicately balanced. These forces are complicated and to some extent inadequately explored. Basically, in good health, there is a delicate relationship between the various components of personality, the id, the ego and super ego, and the environment.

At this point we do not wish to elaborate on the development of personality but merely to discuss the significance of the emotional climate in which the child is reared. The more the nurse knows about the child's physiology, anatomy and illness the better she can serve his physical needs. Similarly, the more she understands the child's emotional and social background, the better she can deal with his adjustment to the hospital, his sickness and his personality disturbances.

We will now discuss three types of backgrounds which in their extremes are unhealthy for the growing child.

Maternal Deprivation

Human beings cannot develop in a vacuum. The infant is born into the world helpless and entirely dependent on others for survival. The early relationship with the mother is essential for survival. Gradually, however, the infant moves on to an identification process that not only gives him food and warmth but also a concept of right and wrong. Thus, the beginnings of character structure and personality develop. This opportunity to introject and identify with a person in one-to-one continuous relationship is very important. Where it is absent we see serious disturbances in children. For this reason, it is preferable to place parentless infants in foster homes rather than in institutions. The infant needs a continous human relationship. Too many people looking after him confuse him. He can't begin to know, trust and feel secure with any of them. For the same reason infants should not remain hospitalized for too long. This is why the nurse dealing with the infant should try to give him a great deal of human contact and social stimulation. Nothing has shown the integration of psychiatric principles more than the day when four nurses attended ward rounds each carrying and cuddling a small infant in her arms, and this was viewed as natural by the staff.

We have all seen grossly deprived children come into hospital. It is very gratifying to see how they improve in response to adequate nursing and human stimulation. Maternal deprivation in infancy may lead to listless, apathetic and unimaginative children who may develop shallow, incomplete personalities in later life.

Maternal Rejection

Mothers, for many reasons, may reject their children. Children who are rejected find it very difficult to develop the first prerequisite of a healthy personality — a sense of trust. Manifest rejection of children in our society is not socially approved. Dislike and resentment of children is usually hidden very skillfully. Frequently, a mother is not aware that she really rejects her children. Rejection may take the form of overprotection. The overprotective mother appears to bend over backwards to take care of the child and give him everything he needs. This outward behavior may be a compensation for her real emotions. Such mothers often sacrifice a great deal to prove to the world that they are "extra special." Basically, they want to convince themselves that their negative feelings towards the child do not exist. The nurse must be very sensitive to meet the needs of the rejected child. Usually in cases of total neglect the doctor will bring in the trained social worker, and, if necessary, the juvenile court.

Maternal Overprotection

Maternal overprotection is a form that unconscious rejection often takes. It is usually related to guilty feelings on the part of the mother. This is an emotional climate frequently seen and also one to which nurses often react poorly. "He is spoilt" may describe the situation accurately but the usual attitude that accompanies this remark is not conducive to good nursing. The "spoilt" child is as unhappy and disturbed as the obviously deprived or rejected child. The nurse here is likely to get involved with the parents, too. The proper handling of such parents requires a great deal of skill if it is to be geared to the total needs of the hospitalized child.

We have already indicated that rejection may be camouflaged by overprotection to be socially acceptable. Overprotection is usually of two sorts:

1. The domineering, controlling, stifling kind of mother-child relationship where the child is never allowed to grow up and have a mind of his own.
2. The over-indulgent permissive mother-child relationship where the child is in constant control of his mother and the home. Here the child has never been allowed to experience any reality controls or limits.

The good nurse realizes how difficult it may be for the first child to have enough courage to *make* requests and how equally difficult it may be for the latter to *stop making* demands. Further, a nurse is prone to react to these situations not as if she were a partner in a healing team but rather as if she were the child's mother. More difficult situations may arise where the nurse over-identifies with the child and relives feelings reminiscent of her own childhood.

Play

Play is another important medium through which children grow and develop. The nurse should have some clear information regarding its importance. In play the child exercises his muscles and increases his coordination. Here children meet and learn about other children. They also develop their ability to get along with each other and to cooperate on joint projects.

Play provides the education for the young child. In this way he learns about the world around him and the people who live in it. Play provides, too, for emotional expression and is a natural outlet for feelings of hostility and aggression. Much of a child's personality and "self" concept is developed through play and its simple forms of role taking. Play provides an opportunity for children to learn how others feel about them. It also opens opportunities to develop skill in shifting from one role or type of behavior to another.

Thus it is that *planned* and *unplanned* play activities are part of the life of the child and therefore should be part of the life of the children's ward in a hospital. One may have to modify certain types of play to meet the needs of special disabilities of sick children but one should not curb it. Children cannot be expected to lie in bed like mummies even if a doctor thinks it is good for them.

Interpersonal Relations

Two of the most important influences on the emotional and social well-being of children in the hospital are their relationships with the nurses, and the nurses' relationships with each other and the rest of the staff. The latter is important because the interpersonal relations of the staff determine the amount of teamwork or coordination of work on behalf of the child patient. Recent studies also suggest that problems among staff are played out in the relationships with patients and distort these relationships. Certainly, a staff that gets along well together is going to be happier and more at ease.

The relationship of the child with the nurse is determined as much by the feelings and attitude of the nurse as by the child. A nurse with a confident, healthy self concept, one who understands herself, is most likely to develop relationships with higher potentialities. The childhood experience of the nurse often comes out in her relationships with other children. Student nurses — being in their late teens — are often upset by children in their early teens who are facing some of the same problems of adolescence that

they themselves have not yet fully worked out. A child may touch off tension in a nurse by behavior reminiscent of her own life experiences.

Being a "student" nurse makes these relationships all the more complicated and difficult. First, the student is not yet a nurse but must carry out many of the duties of the regular nurse. The student is usually aware of this although her patients are not. Second, the nurse, and especially the student, is at the bottom of the hospital's hierarchy. Hospital staffs are very aware of this. A great deal of the normal procedures within the hospital framework and the student nurse program perpetually reinforce this hierarchy. In a general adult hospital she may have to follow out orders of the adult patients and it is questionable who has more authority — the older adult patient or the young student nurse. In the case of children the student feels she should be in the authoritative position — often the reverse of her relationship with a mature adult patient. She may take advantage of this authority and *boss* the children to raise her own self-esteem. Again, the student nurse is somewhat isolated in the community as well as in the hospital.

Nursing, in the interpersonal sense we have been describing — is not significantly appreciated by the average physician. The doctor only too often is more concerned with the efficiency with which his orders are carried out than with the spirit in which they are made available to the sickly child.

Parents of children constitute another group with whom the student nurse is likely to have difficult relations. They represent a challenge and a threat to many students. When the parents are present they are more important to the child and the nurse's ego may suffer. The parents, too, seem to represent a higher authority than the nurse and this may challenge her — as if to say: "Well now, what kind of a job have you been doing with our child?" The student is a threat to the parents in the same way and this increases the likelihood of difficulty in the nurse-parent relationship.

The student nurse usually does not receive the guidance and supervision that is given to late adolescents in other areas of professional training. In college, for instance, these girls would find a great deal of help available in the form of big sisters, faculty advisers, guidance counsellors and deans of women. Many hospitals give their students adult responsibilities on the one hand and yet treat them as children in their private affairs. The student nurse needs an atmosphere of warm acceptance with her supervisors as well as an opportunity to talk over her work, her patients and her problems. At times short talks and a closer personal contact with the senior instructors will suffice. At other times group discussions under competent leadership are indicated and even, occasionally, special counselling is necessary for the student as well as for the staff nurse dealing directly with the student nurse.

The question might be raised as to how well the schools of nursing are meeting the responsibilities of making the student aware of these basic areas of functioning. It would seem that many schools are too concerned with temperature and pulse charts, trim beds neatly arranged in rows, and a rigid atmosphere of discipline, propriety and authority organized in a hierarchy from the director of nursing down.

Understanding the total needs of a patient is more than learning skills and facts. It means the acquisition of a basic understanding of personality in general and one's own personality in particular. A major goal for nursing schools in addition to supplying basic knowledge should be the growth and development of the student nurse into a mature personality in order to contribute more fully to the clinical healing team of a modern hospital ward.

Thus it is that the learning experiences of the student nurse are rather unique. The many difficulties that are inherent suggest a need for greater understanding of their responsibilities and of each individual student's reactions. Further provisions within the hospital for helping the student nurse develop appropriate and satisfying interpersonal relationships especially in the ward setting are mandatory. And last but not least a plea is made for the physician to develop a keener awareness of all the intricacies involved in pediatric nursing beyond the physical ministrations to the sick patient.

The Parents' Point of View

CHRISTINA F. JAMES

WE HAVE BEEN looking at the pediatric setting from the viewpoint of the doctor and from the viewpoint of the child. How does it appear to the parent? As illness is no respecter of persons or classes, any parents may be affected by the hospitalization of their child. In our society the hospital caters to rich and poor, the educated and the uneducated. There will be parents who have had a good deal of experience with hospitals and those who have had none. There will be Canadians with a good understanding of the whole community, including the hospital, and there will be foreigners to whom everything is strange. In the latter group there will be people from other lands where hospitals are only for the dying or the indigent. There will be parents who speak other languages and who cannot communicate with the staff with any degree of satisfaction to themselves or to the hospital personnel. There will be parents who are extremely poor and have been deprived in every direction, in turn being unable to give their children what they want to give. To these people the hospitalization of their child is just one more blow. There will be parents who have every material possession and some who think that money can buy anything, even health. To any of these parents the hospitalization of their child will present some problem.

The inclusion of the parent viewpoint in these discussions is a recognition of the fact that hospital staffs tend to concentrate on the patient and to forget the rest of the family. In the pediatric setting, we forget that the child is part of the family group and that what affects the rest of the group will affect him even though he is away from them and in hospital. How he gets along when separated from them is dependent not only on the well-being and the attitude of the family at the time, but what has gone on before. The parents' attitude towards hospitals in general and towards the child's admission in particular will condition the child towards this procedure.

Probably the most important factor influencing the parents in their attitudes is their ignorance of procedures. How can they prepare their child for hospital when they do not know what to expect themselves? It is true that this does not occur to some parents at all, but nowadays many know that children should be prepared and would like to do it, if they were able. Even a well-educated parent may be ignorant in this respect, and the better educated he is, the more diffident he may be to show his ignorance or to appear to ask silly questions. This has led to quite unnecessary pain for the parents and for the children. Procedures which seem quite simple to those of us who work in a hospital are terrifying to the uninitiated. In this class are the various tests such as an encephalogram or those which require the insertion of a needle into a vein. Very often parents, instead of asking questions, will go away and discuss them with other members of the family or friends who are equally ignorant. They may build up an increasing fear about what is happening to their child in hospital.

Another type of parent, the one who is not very well-educated and possibly has led a deprived life, or the one who has come from another country and does not know what is normal and what is not normal in this country, will not ask questions because he feels he has no right to the information. He looks at the large institution with awe and respect. It seems to him extremely complicated, as we will admit it is. The doctor appears as an authoritative god and the nurse as a very efficient person, far above them. The parents feel inferior and know that they cannot compete with these efficient people in the care of their child. They may also have a

Mrs. James is director, Social Service Department, Montreal Children's Hospital.

feeling of failure or that they are to blame for the condition which has necessitated the hospitalization.

These feelings of inferiority and guilt will be very much increased if any member of the hospital staff criticizes the care given to the child before admission. It is very difficult to avoid this when one is faced with an obviously physically neglected child, or one who has been ill-prepared for admission. The hospital staff, naturally, has a strong reaction to the sight of a dirty, ill-clad or ill-nourished child. There is an equally strong reaction when a staff member observes a parent lying to a child about his admission, trying to skip away when the child isn't looking, or something of that sort. If the parent, at this point, is met by criticism, even in the manner of the staff member, his guilt may increase or he may feel threatened or resentful. He will become what we call the uncooperative parent, because actually he is not included in the team. We all know that we need the cooperation of the parent and yet we may unwittingly exclude him.

The separation of the parent from his child when he leaves him in hospital is probably the most painful part of the whole hospitalization. This is especially true if it is the first time that the parent and child have been away from each other. It is particularly hard when the child is very young and the hospitalization cannot be explained to him. Parents have often described the terrible feeling of loss when they leave their baby or small child in the hands of strangers. Naturally this is slightly lessened when the period before the first visit allowed is short and the visiting days are frequent. We know that in some countries the mothers are allowed to stay with small children. I believe that many mothers in this country would do so if it were possible. Some mothers who have been breast feeding their babies find it very hard to give this up. In some hospitals it is possible to arrange for this to be continued. Where it is not the practice most mothers would hesitate to ask for this privilege.

The day of admission is hard for the parents in another respect. Very often they have to wait for long periods in the admitting department. There they may observe many terrifying things: such as the admission of children who are very ill, or have been injured. Some of these things appear gruesome to them. Sometimes the attitude and manner of the staff looking after these serious cases appear very off-hand and callous to a parent. They interpret the attitude of the staff by their own feelings and usually cannot see the difference. During this waiting time they go over all the things that they might have done to prevent their child's illness, and they wonder if they are doing the right thing to trust him to these strangers. If it is a question of elective surgery, these doubts will be aggravated. If the child is suffering from a congenital condition, they will go over and over their guilt and their questions as to the causes of his condition and their relation to their own behavior. They may feel guilty because actually they are glad to have him admitted because they have been ashamed of his condition, which may make him and them conspicuous. Maybe they have found it very difficult to love this child because he really appeared to be repulsive to them. If this is the case it will be very hard for them to leave him in the hospital because they cannot bear the feeling of relief at getting rid of him. It is actually what they have been longing to do right along but they knew it was wrong because the child is theirs and is their responsibility. They do not realize that few people can meet these problems without help. Unfortunately they are usually ashamed to ask for help.

Parents have various ideas about visiting the child in hospital. Some would like to come very frequently but are diffident about pressing this point. Sometimes, when the parents live out of town, they actually have no money with which to travel to see the patient. Very seldom would a parent like to explain this but would be much more likely to stay away and appear not to care. The same applies to parents who find it difficult to get to see the child in hospital because of the responsibilities in regard to the care of other children. Sometimes parents feel that they should not visit

because every time they do so, the child cries when they leave. They think they have upset him and that he will be better off if they do not see him at all. Some parents feel that they have no rights in regard to visiting — that they are interfering with the procedures on the ward. Some parents feel very inadequate as visitors. Their manner with the child will be unnatural because of the strange surroundings in which they find themselves. This is particularly true when any isolation procedure is necessary. They do not know what to talk about with the child. He has become a stranger to them. Sometimes they are too cheerful and unnatural. They are afraid to talk too much about the home in case he will be homesick. They don't want to tell him of anything that is going wrong in case he will worry. The relationship between parent and child becomes so unnatural that the parents cannot give the child the usual support and in turn the child cannot confide in the parent.

When the staff places all the attention on the child, to the exclusion of the parent, all these things are exaggerated and the parent comes to feel that he is quite unnecessary and is in the way. When the mother or father tells staff members of the child's habits or tastes and no one seems interested, they feel rebuffed or hurt. They lose confidence in these hospital people and begin to wonder how the staff can possibly understand their child or how they can give him proper care, At this point they may become very demanding because they are fearful and distrustful. They may mistake the brusqueness of a busy staff person for lack of interest in their child.

The hospital and the hospital staff present a real threat to parents. The staff of the hospital is doing everything in its power to ease the adjustment of the child to strange surroundings and painful procedures. This includes the giving of love and the giving of material things. It also includes a very permissive attitude with the minimum of discipline. The parents begin to worry about how they are going to manage when the child comes home. Some have a feeling of injustice. How can they follow the doctor's orders which include certain restrictions of activity when the child has been so free in the hospital. They have a feeling that this is not fair to them. An only child may have been very happy with the group in the hospital. This presents another threat to the parents. If there has been disharmony in the home and an unloving atmosphere, the parent may worry about how happy the child will be when he gets home. When the child appears so happy in the hospital the parent may have a terrible feeling of jealousy. A mother may feel that the child will not love her any more, but will prefer the hospital staff.

Some parents who are loving may feel deep sorrow that they have not been able to give their child what he gets in the hospital. This is very well described in Gabrielle Roy's novel "The Tin Flute." There is a description of a child who lived in the poor part of the city and was admitted to hospital. The author tells of the joy of the child when he has his first orange and how he would look up at the nurse as at an angel. There is a very vivid portrayal of the mother visiting this child, observing these things and walking sorrowfully home with such deep regret that she could not give her child what she would like to have given.

This feeling of inadequacy is not only in regard to material things. Most parents have some fear that they will not be able to look after their child properly when they take him home. Some of them when questioned will protest that they can do so. They may be afraid that it will be suggested that he be sent to a convalescent home and they cannot bear a further separation or the idea that they are not fit parents. This fear may prevent them from asking necessary questions and from making sure that they understand about the care needed. Some of them feel that they do ask adequate questions but that they cannot get information. They say that they are always told such things as "that the child is doing as well as can be expected," or that his "condition is the same," or one of these stock phrases which only irritate. Some of the parents are so overcome by what they must face in the diagnosis or the prognosis that they actually do not hear what is

said to them by the doctor and they forget all the practical questions which they meant to bring up.

With all these fears, worries, doubts and other emotions in connection with the child's hospitalization, we realize that the parent who comes to the hospital with her child, though she may have misgivings, has sufficient trust in the hospital staff to believe that something can be done to alleviate the child's suffering and distress.

Some Thoughtful Conclusions

MADELEINE FLANDER

RESPONSIBILITIES OF THE NURSE

The nurse has technical responsibilities in the treatment of sick children and must be observant and meticulous in detail. She also must nurse the child as a person. To do this she requires information which will help her interpret the personal needs of her patients, namely, knowledge of growth and development, knowledge of play, and understanding of the hospitalization to the child and his family. Thus, with an adequate body of knowledge and understanding she could be expected to make nursing care plans for individual patients. With self-knowledge and practice she would be able to see and fulfil her own responsibilities.

To give this total care the nurse functions as a member of a treatment team and must have contact, communication and good relationships with others. She must know the general plan of medical treatment and rehabilitation. The nurse is the logical, central, focal point for integration of services to the child.

IDEAS ABOUT THE ROLE OF THE NURSE

These depend to some extent upon the age and experience of the student. The older student may be less able to think of herself as a learner, less flexible and less able to accept teaching and supervision but she is likely to be more mature as a person.

The ideas of students about nursing relate often to physical care and treatment. To many, the ideal nurse is seen as being patient, perfect in techniques and routines, skillful and efficient, able to meet the patient's emotional needs, kind, thoughtful, sympathetic, clean, neat and professional. She expects to be treated with deference and respect and to be able to restore order in chaotic situations. Most, automatically, expect the tidiness, the quietness and the smooth running routine care that is often possible in adult nursing.

In childrens' wards the student faces a different setting new kinds of relationships and a different focus and emphasis. Some of her ideas are interfered with. The children, the wards, the beds and she herself may get mussed and untidy. Procedures may take longer because she has to establish a relationship and play with the children before starting to work. She is faced with problems of behavior, limitations and discipline. The atmosphere may appear much too permissive to her as her own ideas about discipline are interfered with. She may fail to grasp the real standards. She may expect all children to be attractive, pretty and to react to love, then find that this is not true. She finds that a larger number of her patients are completely dependent and demand much more of emotional giving from her. Frequently she shrinks from performing painful procedures upon infants and small children. She finds that she must recognize her role as substitute for the parent but must respect the rights of parents and correlate her work and behavior with them. They may be very distraught, upset, overprotective or neglectful.

The nurse's reactions may include feelings of inadequacy, frustation, fatigue, tension, guilt, fear, dislike. These are normal but students need help with them if the pediatric experience is to be a positive influence in their

personal and professional growth.

Suggestions for Helping Students

Careful screening and selection of applicants before admission to schools of nursing are basic to effective student nurse training programs. These young women come in training with great enthusiasm for the task ahead and the faculty members should try to help them maintain and channel this enthusiasm.

Sound basic training in the principles of nursing practice will help the student to feel secure in carrying out her responsibilities.

Head nurses, teachers and directors of nursing should establish effective working relationships with students. It is their responsibility to help the student establish satisfying work and play relationships with her fellow students when she seems to need help of this kind.

The student should be involved, when she is ready, in planning ward procedures and policies and share in the responsibility for carrying out the plans. She should be helped to understand that she is a vital member of the ward team. One of the steps in achieving this is by giving her a complete orientation to departments of the hospital.

The rights of the student as a person should be respected. She should know in advance of proposed changes in her ward assignments or affiliations. Her welfare and interests should be considered in scheduling her free time and her hours on the wards. She has need of recognition for a job done well.

The student should be briefed fully prior to entering any new learning situation and especially when it involves an affiliation in another hospital. She should be told realistically about what to expect in the new situation and helped to understand why the experience is considered to be a necessary part of the program. Older students might help to interpret to younger students.

Levels of performance expected of the student nurse should relate to her previous experiences and individual capabilities. There should be an effective grading of the responsibilities she will assume so that she may prove adequate for them.

The affiliating hospital has a responsibility to see that new students are introduced to the new situation and that they receive a clear picture of what is expected of them.

On return to the home school, guidance should be given to students to help them integrate new ideas and skills into their total nursing experience.

There should be interchange of information and ideas between all home hospitals and their affiliating schools since the student is best served when training programs are coordinated.

Reports, records, interviews and other methods should be used to help various staff members to know and assist the student.

All students are apt to suffer a mid-training slump. This is a normal occurrence and the staff should expect and plan for it. Curriculum plans should provide for the increased support and recognition which the student will need at this time.

The advent of modern treatment with the sulfone drugs is completely altering the psychological aspect of leprosy. The frequent need for only a short isolation period followed by home treatment or periodic visits to a clinic, the arresting of the disease by modern therapy, making it non-transmissible and effecting apparent cures, are breaking down the age-old attitudes and prejudices of the public that make outcasts of the victims of this disease.

Almost all countries have legislation on leprosy, but an essential factor in any anti-leprosy campaign is adequate, up-to-date legislation aimed at prevention of the disease, early and more adequate diagnosis and treatment. The organization of a campaign for the eventual extirpation of leprosy from the Western Hemisphere has been advocated. The possibility of eradicating leprosy exists today, just as in the case of syphilis or smallpox but, as in the case of those diseases, it would be far from an easy or inexpensive task.

— Pan American Sanitary Bureau

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It is a man's own fault, it is from want of use, if his mind grows torpid in old age.

— Samuel Johnson

LE SOIN DES ENFANTS

SUZANNE GIROUX

AU COURS DE MES VISITES dans les écoles d'infirmières, l'on se plaint dans presque tous les hôpitaux généraux de la difficulté éprouvée au recrutement d'infirmières pour le service de pédiatrie et particulièrement pour les pouponnières. A quoi attribuer cette difficulté?

C'est ce que nous allons ici essayer de trouver. Les qualités du coeur ne sont certainement pas en cause car nos infirmières sont généreuses et dévouées. S'agirait-il d'un manque d'intérêt envers les enfants? Peut-être! Manque d'intérêt qui pourrait s'expliquer par une connaissance insuffisante de l'enfant et des soins qu'il requiert.

Nombre d'infirmières ont été formées par des surveillantes n'ayant reçu pour toute formation que celle que donne le cours de base; malgré toute leur bonne volonté, elles ne pouvaient donner ce qu'elles-mêmes n'avaient pas reçu. Il y avait aussi la pénurie de manuels en français sur les soins à donner aux enfants et jusqu'à ces dernières années un petit nombre de pédiatres.

Le fait de passer d'un service de malades à celui de la maternité qui est presque toujours dans nos hôpitaux logé sous le même toit fait quelquefois oublier que l'obstétrique est de la médecine préventive. Les infirmières sont portées à considérer les nouveaux-nés comme des petits malades et comme il n'y a pas de maladie le service semble monotone et il en résulte un manque d'intérêt. Souvent, aussi, la surveillante éprouve le même sentiment que l'infirmière de service; elle occupe ce poste par devoir; qu'y a-t-il d'intéressant, dit-elle, à changer des couches, à donner des biberons, à porter les bébés aux mères, j'ajouterais *le moins souvent possible!*

Que de beaux programmes nous pourrions amorcer dans nos maternités si nos infirmières connaissaient mieux le développement de l'enfant, cette merveille, le transfert affectif entre la mère, ou le substitut de la mère, et l'enfant, les facteurs psycho-sociaux pouvant affecter la famille; l'infirmière formée à toutes ces connaissances comprendrait mieux l'importance de son rôle, la grandeur de sa mission.

Comment expliquer, autrement que par le manque de compréhension et de connaissance, le taux élevé de la mortalité infantile dans notre province, le plus haut de tout le Canada! Le grand nombre de naissances serait la cause d'enfants faibles? Il semble que les progrès accomplis ces dernières années sont la preuve du contraire.

Le niveau de vie est-il bas? Les salaires n'ont jamais été si élevés et notre niveau de vie ne se compare-t-il pas avantageusement à celui des autres provinces?

A mon avis, le manque de préparation des infirmières enseignantes et surveillantes en pédiatrie et particuliérement chez les nouveaux-nés, est un des facteurs contribuant à maintenir un taux élevé de mortalité chez les enfants. Je m'appuie, en m'exprimant ainsi, sur les paroles suivantes extraites du rapport technique de l'OMS No. 24, du Comité d'experts des soins infirmiers:

> Les infirmières qui assument des fonctions d'ordre pédagogique dans les écoles d'infirmières de toutes catégories doivent avoir bénéficié d'une préparation complémentaire supérieure à celle que comporte l'enseignement de base.

Et voici d'autres paroles qui sont de nature à nous faire réfléchir en considérant le taux élevé de notre mortalité:

> Il est intéressant d'observer que, dans les pays où le perfectionnement des soins infirmiers ne va pas de pair avec les progrès de la médecine, l'état de santé de la population ne reflète pas ces progrès.

Quel est cet enseignement supérieur que doit recevoir l'infirmière?

Premièrement, une connaissance approfondie de la matière considérée sous tous ses aspects. Si l'infirmière se destine au soin des nouveaux-nés, ces

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Mlle Giroux est visiteuse officielle pour les écoles d'infirmières françaises de la province de Québec.

études couvriront tout le cycle de la grossesse. Le but de l'infirmière dans une pouponnière est de donner des soins experts aux nouveaux-nés et aussi d'aider les membres de la famille à se préparer, à comprendre et à se tirer d'affaire dans toutes les situations qui peuvent se présenter; elle doit aussi contribuer à l'amélioration constante des soins aux nouveaux-nés. L'infirmière a donc trois tâches à remplir: donner des soins aux enfants; établir des relations parents-infirmière; et enseigner.

Pour bien connaître la matière, il ne suffit pas de travailler pendant quelques mois dans un service; l'infirmière devra suivre un programme spécialement préparé et dirigé par une autorité compétente, ordinairement une université.

Deuxièmement. Le programme doit comprendre un enseignement théorique et un stage pratique dans un ou plusieurs hôpitaux et dans les cliniques maternelles des services de santé. Le programme théorique comprendra l'étude des statistiques, rapports et manuels sur la matière.

Parmi les infirmières qui s'inscrivent pour ces cours, on choisira de préférence celles ayant au moins une année d'expérience en obstétrique. La surveillance de ces étudiantes sera confiée à l'institutrice chargée du cours. C'est elle qui assurera la coordination de l'enseignement et de la pratique, de même que l'intégration de l'enseignement de l'hygiène — physique et mentale — dans la famille, lors des visites à la clinique et à l'hôpital.

Il va sans dire qu'une infirmière se destinant à donner des soins aux nouveaux-nés approfondira ses connaissances de l'enfant. L'infirmière doit viser à devenir experte dans le domaine où elle exerce et ce qui est nécessaire pour interpréter intelligemment les besoins du nouveau-né et lui apporter tous les soins immédiats et continus durant la période néonatale. Pour atteindre ce but, voici les connaissances qu'elle doit posséder:

1. Connaître et comprendre le développement de l'oeuf fécondé, de la conception à la naissance.

2. Habileté à préparer et à exécuter les soins aux nouveaux-nés. Pour atteindre ce but il faut connaître le mécanisme respiratoire de l'enfant avant sa naissance, comment s'établit la respiration, les changements physiologiques qui s'opèrent à la naissance et durant la période néonatale; dilatation des bronches, équilibre de la respiration pulmonaire, conservation de la chaleur, digestion, équilibre du métabolisme, de l'eau, la sang à la naissance et durant la période néonatale, tendances du nouveau-né à contracter certaines maladies, etc.

3. Habileté à évaluer les soins dont le nouveau-né a besoin et à lui donner ces soins:

A. Connaître les besoins de l'enfant et être capable de lui donner les soins dont il a besoin, par exemple:

(i) Connaître et appliquer les moyens de réchauffer le nouveau-né et conserver la chaleur du corps.

(ii) Connaître et donne avec habileté les soins concernant le cordon ombilical, les yeux, les médicaments, etc.

(iii) Connaître les méthodes d'identification des nouveaux-nés, aspects légaux.

B. Habileté à observer et à apprécier l'enfant normal au point de vue physique et psychique afin de noter toute déviation et les rapporter immédiatement. Pour cela il faut être habile pour mesurer, peser le bébé, observer les os, les muscles, fontanelles, la position, la coordination des mouvements, la peau, yeux, oreilles, nez et bouche; les pleurs, expression de la face, respiration; le sommeil, l'alimentation, l'élimination, la température et les organes génitaux.

C. Habileté à tracer des plans de soins à donner aux enfants déviant de la normale. Pour cela il faut connaître:

(i) Les signes et symptômes des conditions suivantes: atélectasie du nouveau-né, traumatismes craniens, paralysie, maladie hémorragique du nouveau-né, difficultés des prématurés.

(ii) Connaître les troubles émotionnels que peut causer au sein de la famille la naissance d'un enfant anormal et être capable d'aider la famille à s'adapter à une telle situation.

D. Faire connaître davantage les principes qui sont à la base de l'alimentation

(1) *Guide for an Advanced Clinical Course in Obstetrics*, National League for Nursing.

de l'enfant, la technique de l'alimentation maternelle, l'adoption par la mère et l'enfant de l'alimentation artificielle. Pour cela l'infirmière doit connaître:

(i) Le rôle des hormones dans la lactation.

(ii) Les facteurs physiques et psychiques favorisant une bonne alimentation maternelle chez les nouveaux-nés.

(iii) La technique de l'alimentation.

E. Habileté à travailler avec la mère et le père pour leur aider à faire des plans à l'avance en vue de la naissance de l'enfant afin de leur permettre d'organiser la vie de la famille. Pour cela elle doit être capable:

(i) D'évaluer les besoins de la famille après avoir analysé son attitude, ses réactions et le milieu.

(ii) Expliquer les besoins particuliers du nouveau-né.

(iii) Expliquer les principes du soin des enfants, de leur développement, en tenant compte des conditions économiques, sociales et émotionnelles de la famille.

Troisièmement, utiliser adéquatement les ressources qu'offre la communauté afin de répondre aux besoins sociaux et économiques de la famille et d'en assurer la santé.

Voilà les connaissances que doit posséder une infirmière appelée à donner des soins intelligents aux nouveaux-nés; il va sans dire que si une de ces infirmières est appelée à devenir surveillante ou institutrice, elle devra se préparer à cette nouvelle tâche.

L'infirmière spécialisée en pédiatrie, en plus des connaissances que nous venons d'énumérer, devra continuer à étudier le développement normal de l'enfant afin de pouvoir en reconnaître les déviations, les moyens de les prévenir et de les corriger.

Il serait trop long de donner dans le cadre de cet article les détails du cours. Qu'il suffise de rappeler que le soin des enfants demande une préparation dépassant celle que réclame le soin des adultes. L'enfant en santé ou malade ne se révèle qu'à ceux qui le connaissent et ainsi le comprennent. C'est un être mystérieux renfermant tout un passé et dont l'éveil à la vie se fait entre nos mains.

Espérons que nos enfants seront accueillis par des infirmières compétentes, c'est-à-dire renseignées, compréhensives et sympathiques.

Ontario

The following are staff changes in the Ontario Public Health Nursing Services:

Appointments — *Noreen Noonan* (Charlottetown Hosp., Univ. of Toronto) to Deep River. *Ila (Wilton) Tuff* (St. Thomas Memorial Hosp., Univ. of West. Ont.) to Elgin-St. Thomas H.U. *Marilyn (Spear) Wilson* (Toronto Gen. Hosp., Univ. of West. Ont.), *Lois (Eddie) Suggitt* (Ottawa Civic Hosp., U. of T.), *Julia Liphardt* (T.G.H., U. of T.), *Mary Rust Moore* (T.G.H., U. of T.), *Celeala (Maloney) Percival* (St. Michael's Hosp., U. of T.) to Etobicoke Township B.H. *Elizabeth Zadanyi* (Hamilton Gen. Hosp., U. of T.) formerly with Kent Co. H.U. to Haldimand Co. School Health Service. *Mavis Barker* (U. of A.) to Hamilton Dept. of Health. *Florence Stewart* (T.G.H., U. of T.) to Halton Co. H.U. *Lassy Malowany* (Winnipeg Gen. Hosp., U. of T.) formerly with North York Township B.H. to Kenora-Keewatin-Dryden Area H.U. *Lillian (Garrett) Stewart* (Ottawa Civic Hosp., McGill Univ.) to Leeds and Grenville H.U. *Ethel Tingley* (O.C.H., U. of T.) to Lennox and Addington H.U. *Joan Cogdon* (Metropolitan Hosp., Windsor, Univ. of West. Ont.) to Board of Education, London. *Katherine Buchan* (Victoria Hosp., London, Univ. of West. Ont.) formerly with Kent Co. H.U. to Middlesex Co. School Health Service. *Jean Marshall* (Wellesley Hosp., U. of T.) and *June Schaefer* (Toronto East Gen. Hosp., U. of T.) to Scarborough Township B.H. *Joan Thomas* (Cornwall Gen. Hosp., U. of T.) formerly with Fort William and District H.U. to Simcoe Co. H.U. *Florence Tomlinson* (Kitchener-Waterloo Gen. Hosp., Univ. of Pennsylvania, U. of T.) to the position of supervisor, Sudbury District H.U. *Geraldine Quantz* (Kingston Gen. Hosp., U. of T.) formerly with Wellington Co. H.U. to Timiskaming H.U. *Mary Molloy* (Prince Rupert Gen. Hosp., U. of T.) to Wentworth Co. H.U. *Ann (Breen) Bobbett* (St. Jos. Hosp., Toronto, Dalhousie Univ.) to York Township B.H.

Staphylococcal Pneumonia

CLARA DEMKO

SOCIAL HISTORY

MRS. BELL was born in England — one of a family of seven children. She completed the equivalent of junior matriculation before going to work as chief cook in the home of a wealthy doctor. When she was 23 years old she came to Canada where she eventually married a C.P.R. locomotive engineer. Mr. Bell died 18 years ago from coronary thrombosis. Mrs. Bell is an intelligent, interesting person with a lively sense of humor.

MEDICAL HISTORY

Mrs. Bell's mother died as a result of acute appendicitis and her father succumbed to apoplexy. Her own childhood diseases had consisted of measles and mumps. Mrs. Bell has had several upper respiratory infections complicated by laryngitis. At no time has she undergone surgery.

She is the mother of eight children of whom seven are alive and well. One daughter died as the result of a heart condition when she was 27 years old. Mrs. Bell's present admission to hospital was made necessary when she developed a severe case of staphylococcal pnuemonia.

DEFINITION

Pneumonia is an acute infectious inflammation of lung tissue in which there is a consolidation or filling of alveoli in infected areas with inflammatory exudate. It is either bacterial or non-bacterial.

Staphylococcal pneumonia is a comparatively rare form of pneumonia. Infection spreads to the lungs from the upper respiratory tract. The distribution is usually lobular and the formation of multiple minute abscesses in the lungs is characteristic. The mortality rate is extremely high — usually 80 per cent of the cases are fatal. Staphylococcus *aureus* — the causative organism — occurs typically in grape-like clusters. It is gram-positive, non-motile, does not form spores and produces a characteristic yellow pigment. It is the most resistant of non-spore-forming organisms.

SYMPTOMS

Usual Symptoms:

1. Severe chills.
2. Sharp chest pain due to pleurisy — rubbing together of pleural surfaces.
3. Dyspnea — caused by interference with free exchange of gases between blood and air due to exudate in alveoli.
4. Respirations rapid, shallow, painful, each inspiration punctuated by a grunt.
5. Cheeks flushed, eyes bright, lips cyanosed.
6. Cough — short, painful, incessant, productive, due to irritation of bronchi.
7. Pulse rapid and bounding.
8. Temperature rises rapidly and may reach a level of 104° to 106°F., due to toxins.
9. Patient feels exhausted, dizzy.
10. Loss of appetite.
11. Patient may exhibit a restless, excited delirium.

Mrs. Bell's symptoms followed this pattern fairly closely. She had frequent chills and severe pain in the left anterior chest. Her respirations were labored and painful, 32 per minute, with considerable dyspnea and cyanosis. She had a troublesome, croupy, productive cough, with blood-tinged sputum. Admission temperature was 102.6° with the pulse 120. Mrs. Bell was very upset and restless, unable to lie still in one position for any length of time. She said she felt "all worn out."

LABORATORY FINDINGS

Upon admission, several laboratory

Miss Demko was a senior student at the Galt School of Nursing, Lethbridge, Alta., when she carried out this study.

tests were done. The white blood count was 17,000 which signified an infection present since the normal is from 5,000 to 9,000. The red blood count was within normal range. The hemoglobin — 11.1 gm./100 cc. of blood — was below the normal of 15 gm./100 cc. The differential count showed the presence of leukocytosis — a result of the demand for enormous numbers of leukocytes to be poured into the alveoli of the lungs. The urinalysis was essentially normal except for a few bacteria, epithelial cells and hyaline casts.

Several sputum cultures were done. At first growths of Monilia *albicans* and a heavy flora of gram-positive cocci in clusters appeared. Finally, after repeated cultures, the causative organism, Staphylococcus *aureus* was identified. It is sensitive to Ilotycin and Chloromycetin.

X-Ray Findings

The first chest x-ray on admission showed a lobar consolidation involving the whole left lower lobe. There was a moderate degree of atelectasis and a thin-walled cavity in the centre of the lobe, 3 cm. in diameter. An x-ray taken 19 days later showed some improvement. There was still a large consolidation with some element of atelectasis in the lower lobe where the cavity continued to be seen. The diaphragm was assuming a more normal position. The final x-ray showed further regression in the lobe. There was still a thin-walled cavity in the apex.

In this case, the cocci passed down the trachea and bronchi and involved the alveoli. An inflammatory exudate poured from the vessels into air spaces. The exudate consisted of leukocytes, serum and fibrin threads. Many of the capillaries gave way and red blood corpuscles were added. This caused a complete replacement of air normally present — that is, the lung no longer contained air in the lobe, but exudate. Slowly the exudate disintegrated, softened and was coughed up as blood-tinged sputum.

Medical Treatment

The primary objective of the medical treatment was to help the natural protective agencies of the body conquer the disease. It was important to identify the causative organism and then treat the condition medically with the specific drugs.

Nursing Care and Treatment

The chief objective of the nursing care was to maintain physical and mental rest. Bed rest was essential, particularly where fever was present. Mrs. Bell had to be kept as comfortable as possible by means of daily baths, back rubs, ample back support, good oral hygiene, regular elimination and adequate ventilation. Unfortunately, she occupied a ward bed, thus was not able to get as much rest as was necessary. She was moved frequently from side to side to help prevent any further pulmonary complications.

An abundance of water and other fluids was required. A patient with pneumonia frequently has a chloride deficit so that it was necessary that sodium chloride be supplied in liberal amounts.

During the acute stage when the patient did not feel like eating, high caloric fluids were given. As Mrs. Bell's condition improved her diet was increased from a fluid to a soft diet.

As she improved, deep breathing exercises were ordered to be done four times daily. These assisted greatly in re-expansion of the lung. This is an extremely important aspect in the nursing care. Postural drainage was also ordered preceding the deep breathing exercises. Postural drainage is a procedure whereby the patient lies over the side of the bed, with his head down, enabling the purulent sputum to drain from the lower lobes of the lungs.

Gradually, Mrs. Bell was able to sit up in a chair for ten minutes each day. This period was slowly increased until she was able to walk with assistance.

Medications

On admission to hospital, Mrs. Bell received crystalline penicillin, 250,000 units every six hours intramuscularly. This was an antibiotic to prevent any further infection and to treat infection present. The penicillin did not appear to bring much improvement so sulphadine, tablets 2, was given orally

every six hours. Still the patient did not show improvement. S.R. Penicillin 400,000 units intramuscularly every 12 hours was substituted. Finally, when the causative organism was isolated and identified, Ilotycin 200 mg. and Chloromycetin 500 mg. were given every six hours. It was found that these two antibiotics were the only ones to which the Staphylococcus *aureus* was sensitive.

Digitalis folia gr. ⅓ was given twice daily to relieve symptoms of congestive heart failure since it acted as a cardiac tonic.

Mrs. Bell was given 1,000 cc. of blood while in hospital to raise her hemoglobin level. Her hemoglobin at the time of discharge was 11.85 gm.

Since rest and sleep were very vital codeine gr. 1 orally was given as necessary to relieve chest pain.

Health Teaching

Mrs. Bell was a very active person. It was necessary to impress upon her the importance of absolute rest and quiet. She was very independent and wished to do a great deal for herself.

It was necessary to teach her the importance of cleanliness and mouth care for comfort as well as for hygienic purposes and the use of sputum cups to prevent the spread of infection.

It was explained to her that good nourishing food and drinking large quantities of fluids were important. The value of postural drainage and deep-breathing exercises was stressed as well as the necessity of moving frequently from side to side. She had to guard against over-activity and take special precautions against upper respiratory infections.

Convalescence

A long convalescent period was necessary for Mrs. Bell — one that had to be carefully planned and followed. Because of her age complete recovery was a slower process especially since she was prone to upper respiratory infections. It was necessary to limit her activity and to be certain that she had ample rest, nutritious food, sleep and fresh air. All possible measures had to be taken to prevent colds and chilling.

In The Good Old Days

(*The Canadian Nurse* — December, 1916)

It is estimated that 25 per cent of our criminals, juvenile and adult, belong to the moron class. These people are expert imitators. Possessed of little originality, they succeed in adopting the manners and customs of their fellows; they learn how to converse in parrot-like fashion, dress in the latest style, and up to a certain level, appear quite like other people.

* * *

Inoculation against typhoid fever has produced a remarkable diminution of that disease among the troops. In two months of 1915 there were 10,869 cases of typhoid reported from the army. In the corresponding period this year there were only 1,798 cases and most of these were in men who had refused inoculation.

* * *

A baby contest was held under the auspices of the local Victorian Order of Nurses. There were over 300 babies. There were eight pairs of twins and one set of triplets, the latter being a great source of curious interest as no one there had ever seen such a trio before. The fond mother was only too proud to have them displayed.

* * *

Operation for tonsils and adenoids often fails to relieve habits of faulty articulation and consequent school retardation. Vocal drill by one trained in speech disorder is the surest way to secure speedy permanent improvement.

* * *

A fund of humorous stories is an excellent asset for anyone who is obliged to be around the sick. Nurses should keep a small book to jot these stories down so that whenever the condition of her patient will warrant a little pleasantry, they will have stories available.

A Greenhorn on the Frontier

RUTH E. EVANS

IT WAS SHORTLY AFTER we went north. We were going to have chicken for dinner. When I went to get the bird ready, I discovered that it had not been cleaned. I thumbed frantically through my big cookbook to find out how it was done! "Take it to your nearest butcher!" it said. With my nearest butcher over a hundred miles away, this was some help! I decided my motto would have to be "Do it yourself!"

So it was with my nursing, I soon found. Who else was there to make the decisions, do the diagnosing, and dispense the drugs? The nearest doctor was also over a hundred miles away.

We had come north, my husband and I, a few weeks earlier. In order that we could spend at least part of the year together I was to establish a nursing service for the Red Cross along 200 miles of the Hudson Bay railroad in northern Manitoba, between Wabowden and Gillam, while my husband was going to teach at Wabowden. We had set up housekeeping in a railway car, which was reconverted to be a "nursing station on wheels."

There were living quarters at one end, while the other end was fitted up as a combined office and examining room, with one emergency bed. In winter, the car was stationed three months at Wabowden and three months at Gillam in order to be connected to the steam. We also had electricity and running water at these points. In summer, the car would visit smaller places along the line.

Fresh from a public health nursing course, I was filled with enthusiasm and ideas for teaching health to everyone! It was all I could do to keep from falling into the trap, as so many of us do, of trying to "change the world in a day."

I soon found out that most of my "flock" were not very interested in any organized program, such as prenatal classes or well-baby clinics. I had to rely on "teaching in the home."

I set out to visit all the families, about eighty in all. One of my first calls was to a woman whose baby had almost died that summer with infant diarrhea. After working around to the question of boiling the water etc., I asked her if she had boiled the bottles and nipples. "No," she said, "What is the use? My baby only goes out and eats dirt anyway!" I still haven't thought of a good answer to that one! And so it was with most of my efforts.

I found living conditions that were both good and bad. In one home, the mother was extremely particular. Her place was scrubbed and polished until it virtually shone. It was a joy to visit her. On the other hand, there were others along the line that were terribly overcrowded, and negligently cared for.

It was a busy year. There had been no regular nursing service previously. Inoculations had been done only sporadically and just the year before there had been quite an epidemic of whooping cough with resultant infant deaths. I set about inoculating on almost every visit I made. We did not have an epidemic that year, and I like to think that perhaps my efforts were not in vain.

Of course, the public health side was only a small part of my work. The sick calls and emergency nursing took up most of my time. The latter was, perhaps, the most important of all. For it is with accident cases or a sudden severe illness that many lives are lost in these lonely isolated places of the bush. It is at such times that the nurse is most appreciated. It made me feel that nurses throughout the north are filling a very definite need.

As I look back now on my own experiences, I can recall several such incidents in my short time "in the bush."

I shall cite only two. I can remember the time that I was called to care for a boy, about 18 years of age, who had

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Mrs. Evans is still working in the northland, residing now in Rupert's House, Quebec.

cut his foot badly with an axe. It was the middle of winter and he had walked home several miles through the bush to reach aid. We arrived at the dwelling about 8:00 p.m. I saw at once the cut would require several stitches. By the light of the one coal oil lamp and a small battery lamp that my husband held, I set to work. I was sure that the wound would become infected, but miraculously nothing so serious happened. Several days later the lad was up and about.

How vividly I can recall, too, another time when I was called to a sick two-week-old baby. All I could get out of the girl who came for me was that the baby "had gone blue." Thinking it must have taken a convulsion, and that probably I could do nothing, I set out with her with some reluctance. We arrived at the home about ten o'clock. The room was filled with kindly neighbors. Although it was midwinter, it was terribly hot inside the small cabin. I was handed a small bundle of blankets. As I carefully unwrapped each one, I could sense that all eyes were on me. I took one look at the baby and knew that I had to do something, and do it quickly — just what I did not know! The baby was terribly cyanosed, and hardly breathing at all. Without stopping to take off my parka, I prepared Coramine and then started in with artificial respiration. (I could think of nothing else to do!) The baby would take a breath and stop, then take another. I felt so helpless! It was such a fine little boy! I silently breathed a prayer and worked on, quite oblivious to my surroundings. After awhile, I was aware of the room gradually emptying, until only the mother and father and I remained. By midnight, the infant's respirations had returned almost to normal and the color had come back. We gave him a little milk before I left. I made several return visits to give penicillin and he recovered completely. To me, it was nothing short of a miracle that the baby lived at all! Several months later the mother brought him in to be weighed. He had grown so much and she was so proud of him.

There were dozens of other cases, of course, that were not so dramatic, but each of them was interesting and sometimes amusing. Life was far from dull! I realize that there are many other nurses who have had far more experience than I. However, does not this life present a challenge to those who like adventure?

There is still a great need for nurses throughout the north. Certainly it is, at times, a great responsibility and the decisions one must make are not always easy. But the life has its rewards — the reward of grateful people, like the young mother in my story. Yes this "frontier nursing" is a challenge for today!

Victoria, B.C. would appear to lead among Canada's principal cities in the proportion of aged in its population, with 17.75% of its citizens over the age of 65. Other cities with a high percentage of the aged are Vancouver 12.81%, Toronto 10.51% London 10.49% and Winnipeg 9.8%. On the other hand Quebec, the nation's oldest city, has only 5.92% of its people over age 65, and Montreal 6.37%. Windsor and Halifax are the only other cities with a figure below 7.

These figures were compiled by Dr. James Tyhurst of the Allan Memorial Institute, Royal Victoria Hospital, Montreal, who made a study of the social situation of elderly citizens under a Federal-Provincial grant. This study shows Canada as a country which is "aging" rapidly. Since 1881 Canada's population has increased by three times, while the percentage of those over 65 has jumped by six times.

Taken by provinces, Quebec is the "youngest" with 5.7% over 65. The others: Newfoundland, 6.5; Prince Edward Island, 9.9; Nova Scotia, 8.5; New Brunswick, 7.6; Ontario, 8.7; Manitoba, 8.4; Saskatchewan, 8.1; Alberta, 7.1 and British Columbia, 10.8.

When it comes to distribution, about 60 per cent of aged live in Quebec and Ontario, but in trends the Western provinces are getting "older" much faster than the east. The percentage of increase in the rate of aged in Quebec since 1881, for instance, is 398 compared with 6,546 in Manitoba and 10,146 in British Columbia.

In 1951, the total over 65 in Canada was 1,086,273 or about 7.7 per cent, which puts Canada in 16th place in the list of countries according to percentage of aged. England and Wales are aging rapidly, with a 1951 figure of 10.8 compared with only 7.5, about our level back in 1931.

Nursing Profiles

October 19 was a day of rare excitement at the University of Western Ontario when **Edna Lena Moore,** Director of public health nursing for the Ontario Department of Health, received the honorary degree of Doctor of Laws, then delivered a convocation address.

Born in Ontario of Irish parentage, Dr. Moore has had a rich and varied career in nursing. After graduating from Toronto General Hospital in 1913, she joined the staff as night supervisor, later becoming head nurse in the emergency department. In 1915 she enlisted with the C.A.M.C. and served in France, England and the Middle East. She was made an Associate of the Royal Red Cross in appreciation of her work.

Returned from overseas in 1919, Miss Moore served for a year as social service nurse with the Soldiers' Civil Reestablishment, then joined the division of preventable diseases of the Ontario Department of Health. In 1925 she accepted a position as supervisor of venereal disease nursing in Olean, N.Y. but returned to Canada two years later as home nursing teacher for the Ontario Department of Agriculture. From 1927 to 1929 she was a field worker for the Canadian Tuberculosis Association following which she spent two years in New York as an assistant director with the National Organization for Public Health Nursing. After several years as chief public health nurse for the division of maternal and child hygiene in Ontario, she assumed her present position in 1944.

Dr. Moore has been active on the boards of many organizations including a term as president of the Ontario Public Health Association. She is a charter member of the Soroptimist International of Toronto.

EDNA L. MOORE

Several new appointments have been made to the faculties of university schools of nursing across the land this autumn. **Alberte Roy** is assistant director of the division of public health nursing, School of Hygiene, University of Montreal. A graduate of Hôpital Ste-Jeanne d'Arc, Montreal in 1930, she holds her B.Sc. in supervision in schools of nursing and her M.A. from Teachers College, Columbia University, majoring in administration in public health nursing. In addition to many years of hospital experience including supervision of the obstetrical department, and later the emergency and x-ray units at Misericordia Hospital, New York, staff work at the Montreal Neurological Institute and at a small Red Cross Hospital in Ontario, Miss Roy has practical knowledge of the problems of district public health nursing. She was on the staff of the Gaspé East health unit for nearly three years, the last half of which she was educational director.

ALBERTE RAY

Ruth Elizabeth McClure is assistant professor of nursing in the School of Nursing at the University of Alberta. Graduating with the degree of B.Sc. from U. of A. in 1942, Miss McClure later obtained her Master of Public Health degree from the University of Pittsburgh. In her chosen field of public health nursing she has had considerable experience in health unit work in Alberta and also in the Venereal Disease Division of the Toronto Department of Health. For a short time she was secretary of the Toronto Branch of the Health League of Canada.

RUTH E. MCCLURE

Vivian B. Kirkpatrick is an instructor in public health nursing with the University of Western Ontario School of Nursing. A graduate in 1942 from Women's College Hospital, Toronto, Miss Kirkpatrick secured her public health sertificate from the University of Toronto School of Nursing, later receiving her B.N. from the McGill School for Graduate Nurses, majoring in supervision and administration in public health nursing. Several years in hospital work preceded Miss Kirkpatrick's entry into the public health field on the staff of Brant County Health Unit. After two years as health supervisor in the W.C.H. school of nursing, she joined the World Health Organization going as nursing specialist to Formosa. Later, under the Canadian Colombo plan, she was nursing adviser at the Lady Harding Hospital in New Delhi, India. This world travel has given Miss Kirkpatrick a wonderful opportunity to add to her interesting collection of international dolls.

Mary L. Richmond is director of nursing at Royal Jubilee Hospital, Victoria, B.C., where for four years earlier she had served as educational director. A graduate from Vancouver General Hospital, Miss Richmond holds her B.N. from McGill School for Graduate Nurses and her M.A. from Teachers College, Columbia University. She was on the teaching staff at the Vancouver General for several years.

MARY L. RICHMOND

Sister Noémi de Montfort has taken over her duties as administrator at Ste.

SISTER NOÉMI DE MONTFORT

Justine Hospital, Montreal, where she had graduated in nursing 15 years before. Sister Noémi's postgraduate work included preparation in hospital organization and management at the Institut Marguerite d'Youville, Montreal. She was made a fellow of the American College of Hospital Administrators in September, 1956. She succeeds Sister Valerie de la Sagesse who has been forced to retire because of poor health.

A graduate of the Hospital for Sick Children, Toronto, **Dorothy G. Hollister** is now the director of nursing at the New Queensway General Hospital, Toronto. Postgraduate study in obstetrics and later in administration of nursing service, at the University of Toronto School of Nursing, plus broad experience in hospital administration have given Miss Hollister a strong background for her new work. She has served as superintendent of Douglas Memorial Hospital, Fort Erie, Ont., of the Great War Memorial Hospital in Perth, Ont., as assistant director at Sarnia General Hospital and, immediately prior to her new appointment, as director of nursing at South Waterloo Memorial Hospital in Galt, Ont.

DOROTHY G. HOLLISTER

SOEUR VALERIE DE LA SAGESSE

Soeur Valerie de la Sagesse quittait à l'automne son poste de directrice de l'Ecole d'Infirmière de l'hôpital Ste-Justine pour celui de consultante en nursing au nouvel hôpital.

Diplômée de Ste-Justine en 1919, Soeur Valerie devenait en 1924 directrice de l'école. Educatrice dans la force de l'âme, elle forma des générations d'infirmières s'efforcant de développer autant leurs qualités personnelles que professionnelles. Durant trois ans elle fut présidente de l'Association des Infirmières de la Province de Québec et montra dans l'exercice de ces fonctions un jugement sûr, un esprit de prévoyance et un grand amour de la concorde. Nous prions Soeur Valerie d'accepter tous nos meilleurs voeux.

In Memoriam

Ethel Hilda (Hennie) Anderson, who graduated from Misericordia Hospital, Edmonton, in 1924, died on February 25, 1956 in Toronto. Mrs. Anderson began her professional career as a floor supervisor at her Alma Mater. In 1927 she became maternity supervisor at the Red Deer Hospital. Ten years later she was made night superin-

tendent at Wellesley Hospital, Toronto. From 1947 until her death, Mrs. Anderson was Provincial Nursing Officer with the Ontario Council of St. John Ambulance.

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Margaret (McCullum) Beach, who graduated from the Ottawa Civic Hospital in 1926, died on August 4, 1956, after a short illness. Prior to her marriage, Mrs. Beach was on the staff at O.C.H.

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Audrey Bernice Elliott, who graduated from Winnipeg General Hospital in 1953, died suddenly at Moose Jaw, Sask., on September 2, 1956. Miss Elliott had worked at the General Hospitals in Vancouver and Brandon prior to joining the staff of Moose Jaw Union Hospital last June.

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Gladys Ellis, who graduated from Saskatoon City Hospital in 1935, died recently.

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Kathleen G. (Trainor) Farrell, who graduated from St. Paul's Hospital, Vancouver, in 1924, died on September 10, 1956.

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Ella Maude Forrest, a graduate of the New England Baptist Hospital, Boston, died at Vancouver on October 9, 1956, in her 81st year. For many years Miss Forrest served as supervisor of the infectious diseases department at Vancouver General Hospital.

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Frances King, who graduated from Toronto General Hospital in 1936, died at Vancouver on August 18, 1956.

Following graduation, Miss King served with the Manitoba Department of Health and Welfare as staff nurse, then as supervisor. In 1945 she enrolled at Columbia University where she secured first her bachelor's then her master's degree, specializing in public health nursing education and administration. She remained in New York with the Community Service Society, serving as supervisor, consultant in mental health and, later, as educational director. She joined the faculty of the University of Western Ontario School of Nursing, in 1949, and was largely responsible for the establishment of the first postgraduate program in psychiatric nursing. In 1950 she headed the basic program of studies in public health nursing which post she filled until her death.

Active in the affairs of both the Canadian Public Health and the Mental Health Associations, Miss King served the London community through the local Mental Health Association, as a member of the Council for Social Planning, and on the executive of the Community Chest. Many public health nurses who had the privilege of studying under her direction will realize most keenly the serious loss her untimely passing has occasioned.

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Mary S. MacDonald, a graduate of Charlottetown Hospital, died at Montreal on September 2, 1956, following a brief illness. Miss MacDonald served with the R.C.A.M.C., during World War II, on the hospital ship, *Lady Nelson* and on hospital trains across Canada. Following demobilization she worked in Halifax and more recently at Queen Mary Veterans Hospital, Montreal.

* * *

Margaret Isobella MacIntosh, who graduated from Royal Victoria Hospital, Montreal, in 1902, died at Montreal on September 27, 1956, aged 86. Prior to enlisting in the C.A.M.C. in World War I, Miss MacIntosh served at R.V.H. as night superintendent, later as supervisor of the outpatient department. Returning to R.V.H. following her war-time experiences, she took charge of the nurses' home until her retirement in 1949.

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Susanna McCauley, who graduated from Hamilton General Hospital in 1920, died there on September 6, 1956 at the age of 77.

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Ethel Patricia (Sunderland) Pinder, who graduated from Regina General Hospital in 1938, was killed in an automobile collision near Virden, Man., on October 4, 1956. Mrs. Pinder served on the R.G.H. staff until she joined the R.C.A.M.C. She served overseas until her marriage in 1943.

* * *

Elizabeth Reid, a graduate of Christ Hospital, Jersey City, N.J., died on September 4, 1956, following a heart attack. Miss Reid had worked for many years in Vermont before returning to her home in Ayr, Ont.

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Sister St. Bertha, who graduated from Misericordia Hospital, Winnipeg, in 1927, died at Montreal on August 29, 1956 following a lengthy illness. She had served as director of nurses and later as superior at Misericordia Hospital.

* * *

Roberta Hope Turnbull, who graduated from Regina General Hospital in 1935, died at Hastings, England, on September 5, 1956. Miss Turnbull had nursed at hospitals in Cumberland and Vancouver, B.C. and at

Mountain Sanatorium, Hamilton, Ont., before going to England.

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Marguerite Wharrey, who graduated from the Ottawa Civic Hospital in 1930, died on March 18, 1956 after a brief illness. Miss Wharrey had engaged in private nursing.

* * *

Caroline Agnes (Ruthven) Wyand, who graduated from Lady Stanley Institute, Ottawa, in 1908, died on August 18, 1956.

Graduation Pictures

Miss Bietsch, director of nursing, with Mrs. E. Richards, Alumnae president and Mrs. W. C. Campbell, past president.

The Multiplex swinging wing-panel presented to the Medecine Hat General Hospital School of Nursing by the alumnae association will be used to house pictures of graduating classes. Photographs are mounted on a royal blue background with a gold border (the school colors). Each panel has a mica covering. There are 10 swing panels — 20 panels for mounting purposes — with enough space to mount the graduation pictures of the next 50 years.

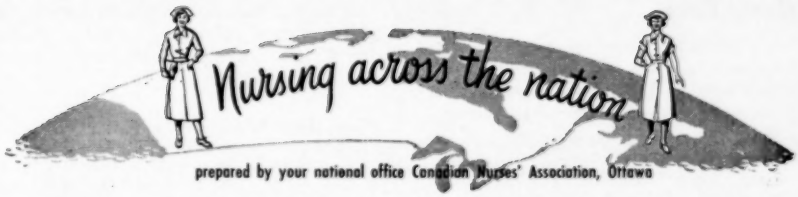
The hospital building was completed and opened in 1890. The school of nursing has been in operation since 1894 with the first class of four members graduating in 1896. The earliest photograph available was that of the 1903 graduates. A total of 492 nurses has graduated since that first ceremony 60 years ago. The album presently contains the pictorial record of 32 graduation groups.

"To perpetuate the memory of those who have gone before and to promote their ideals in those who follow."

ELIZABETH BIETSCH

Without a knowledge of, and a feeling for the past, we cannot build as we should in the present and for the future. We, as Canadians, have been rather neglectful of this truth in years gone by. We have allowed ancient buildings to disintegrate; we have permitted historic documents to disappear and we have, I think, done less than we should have to remind our people of the achievements of our forebears, from whose courage and labor we so greatly profit.

— RIGHT HON. VINCENT MASSEY



I.C.N. Congress

Rome, May 27 to June 1, 1957, will see some 235 Canadian nurses attending the 11th Quadrennial Congress of the International Council of Nurses. Since early in 1956 requests for applications have been received from CNA members. Indications are that we will use our full Canadian quota of 235

The tentative program, which has been distributed to all applicants, gives the following details:

Congress Theme — Responsibility

Meetings of the Grand Council will be held the first days of the Congress. (The Council is the voting body of the I.C.N. and consists of members of the Board of Directors together with four accredited delegates from each active member Association.)

The last three days will be devoted to papers and discussion of: Responsibility for the Selection of Nurses; Responsibility for the Education of Nurses; Responsibility for Nursing Administration.

We are happy to announce that Miss Helen Carpenter, assistant professor, University of Toronto School of Nursing, and Second Vice-president, CNA, will represent Canada as she presents a paper under the general topic: "The Role of the Nurse in the Total Health Program." Other papers to be presented on this theme will be given by speakers from Sweden and Italy.

Representing the CNA will be our President, Miss Trenna Hunter, and General Secretary, Miss M. Pearl Stiver.

Committee Manual

For the guidance of the chairmen and members of national committees a Committee Manual has recently been distributed. Prepared in National Office, this Manual discusses the structure of committees — national, special and subcommittees, their functions, membership, preparation of minutes and reports.

Information about travel arrangements, assistance available from National Office and the Bylaws governing the functions of our five national committees are also included.

While it is designed to explain and facilitate the work of our own Association, the Manual may also be helpful to other groups who function under a somewhat similar organization.

To facilitate committee activities, channeling of information and accurate recording, an outlined procedure is necessary. A manual, however, will not guarantee successful action, for this is dependent on the progressive and thoughtful work carried on by each committee member. May we wish our 75 CNA committee members success in this biennium.

A.N.P.Q. Curriculum Talks

During the past several years, the Curriculum Committee (English-speaking) of the A.N.P.Q. has been working on a revision of its curriculum for schools of nursing. The result, still incomplete, is a distinct departure from the traditional. For three days in September, directors of nursing and instructors from the schools of nursing were brought together to discuss the work already accomplished and to prepare statements of guiding principles for selection of content in teaching clinical nursing. Because of lively and lengthy dicussion of the general concept of disease which must be understood by the nurse before she can give intelligent care, it was not possible to develop content. The Committee hopes that, by further study and discussion, the background of knowledge needed by the nurse will be analyzed and much irrelevant material eliminated.

Home Care[1]

> During the past 10 years, the increasing number of persons requiring long-term care, the high costs of institutional care and of hospital construction and a growing awareness of the adverse effects of prolonged institutionalization have stimulated a keen interest in the provision of care to patients at home.

Hospital Home Care Plans originated with the Montefiore Hospital New York City, as a measure to deal with the problem of an inadequate number of hospital beds and care for the large number of chronically ill.

The Herbert Reddy Memorial Hospital, Montreal, instituted a Home Care Plan in 1950 in cooperation with the V.O.N. The patient leaves the hospital at an earlier date than usual and spends the period before complete convalescence at home. Internes visit the patients under the direction of their own doctors and make reports as if the patient were still in hospital. The nursing service is carried out entirely by the Victorian Order of Nurses. The visiting nurse reports to the Home Care Section of the hospital so that complete records are available. As far as the patient is concerned, the plan has the double advantage of an early return to home atmosphere and conditions and a substantial lowering of the total cost of illness.

1 U.S. Dept. of Health, Education & Welfare "A Study of Selected Home Care Programs" Public Health Monograph No. 35, Washington, D.C.

Adult Education

Who should be more interested in adult education than nurses? Every nurse is a health educator and is called upon to teach people of all ages during the course of her work. Because of this, your Canadian Nurses' Association is a member of the Canadian Association for Adult Education and participated in the meeting of the C.A.A.E. Joint Planning Commission in Ottawa on November 23. Through its relationship with organizations such as the C.A.A.E., the CNA is better able to interpret nursing to the public and in turn to profit from the experiences of other similar groups.

If anyone is interested in becoming an individual member of the C.A.A.E., the address is 113 St. George Street, Toronto, Ontario.

You Are What You Eat[2]

Undernourishment in Canadian families is a health problem found at all income levels. This is due largely to ignorance of food values and indifference to the importance of food to health.

Nurses, because of their direct contact with people in homes, in hospitals, and at work, are in a key position to do some important health teaching with regard to nutrition. The personal approach is much more effective than mere printed words.

However, there are some excellent printed materials available from various sources which will be very helpful to the nurse in teaching "what to eat for health."

A mimeographed list of many of these materials, available from various sources, may be obtained from CNA. A loan folder, containing copies of the materials is also available on request.

2 Pett, L.B., "Nurses and Nutrition" *The Canadian Nurse* September, 1950. 46:9:735.

What's New from CNA

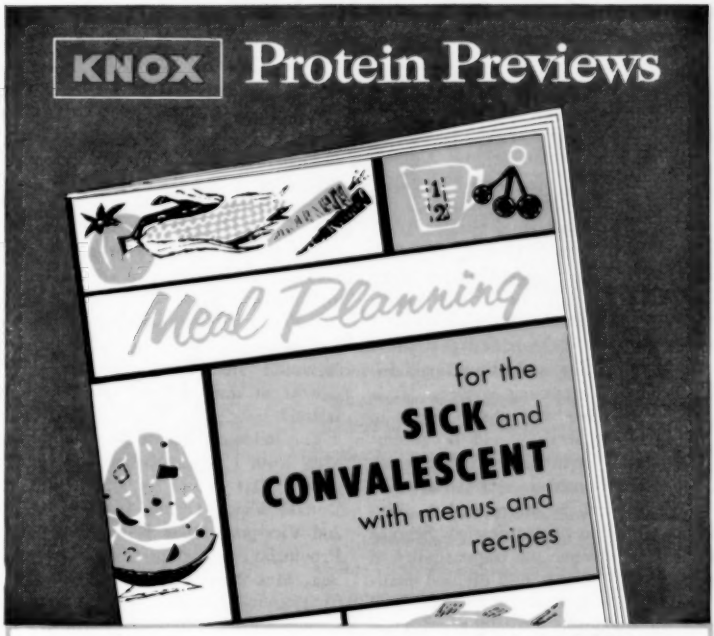
A.B.C. of CNA — a mimeographed leaflet giving up to date information about our membership — by number and by age, employment of nurses, composition of our executive and committees, and a list of associations on whose boards we have representation.

CNA Publications — another leaflet listing all publications now available from National Office.

These are available on request from CNA, 270 Laurier Avenue West, Ottawa.

New Developments

Last February, Miss Gladys Sharpe, Past President of the CNA addressed the Presidents' Conference of the National Council of Women on the topic "Home Care Plans." As a result of this, the Health Committees of the Local Councils will this year be investigating the possibility of Home Care



New Booklet Presents
Latest Facts on Feeding the Sick

Nurses often must devote much time to describing good nutritional practices.

"Meal Planning for the Sick and Convalescent" relieves you of the need for repeating over and over again essential dietary facts. This new Knox booklet presents the latest nutritional applications of proteins, vitamins and minerals, suggests ways to stimulate appetite and describes diets from clear liquid to full convalescent. It offers the homemaker for the first time detailed daily suggested menus for each type of diet, plus 14 pages of tested nourishing recipes.

If you would like copies of this new timesaving Knox booklet, use the coupon below.

Knox Gelatine (Canada) Limited
Professional Service Department CD-24
140 St. Paul St. West, Montreal, Quebec

Please send me ..... copies of the new Knox "Sick and Convalescent" booklet.

YOUR NAME AND ADDRESS

Plans in localities across Canada.

A new committee has recently been set up under the National Nursing Committee of the Canadian Red Cross Society to proceed with a study of Home Care in Canada.

Annual Meeting in Prince Edward Island

THE 35th annual meeting of the Association of Nurses of P.E.I. was held in September with an attendance of 82 members and 6 guests. Reverend John A. Sullivan pronounced the invocation at the opening ceremony, while greetings from Charlottetown were extended by City Councillor F. G. O'Neill and from the province by Dr. O. H. Curtis, Deputy Minister of Health.

In her address, the president, Sister Mary Irene, looked to the needs of nursing service and nursing education on "The Road Ahead." Advances in medical science and population increases make certain a continued and increasing demand for nursing services. "It is dangerous to assume that the upsurge in demand for health services will be accompanied by an upswing in interest in the health professions." The challenge and satisfactions of nursing must still be interpreted to prospective candidates to this profession. Schools of nursing must assume the responsibility of assuring adequate education of the best quality for the expected increased enrolment. This is dependent upon the availability of good teachers. Graduate nurses, in view of this need for instructors, supervisors and head nurses, should make use of any opportunity for postgraduate study. "It is likewise the responsibility of the hospital administration . . . to provide well prepared key personnel and to establish a continuing educational program for these employees."

A highlight of the meeting was the presentation of the nursing service dramatization prepared by Miss F. Lillian Campion, Nursing Service secretary with C.N.A. — "Toward Better Nursing." Head nurses, supervisors and staff nurses from the local hospitals and health services participated. Of equal interest was a panel discussion on accreditation centred about the questions:

1. What is on the record regarding accreditation in Canada and the United States?

2. What was determined at the Biennial Convention regarding a program of evaluation and accreditation of schools of nursing in Canada?

3. What are our responsibilities as an association regarding the evaluation program, the pilot study and the accreditation of schools of nursing here in Prince Edward Island?

The following officers were elected: Pres., Miss Ruth I. Ross, 57 Orlebar St., Charlottetown; 1st Vice-pres., Mrs. Vera MacDonald, King's County Hospital, Montague; 2nd Vice-pres., Miss Katherine MacLennan, Provincial Sanatorium, Charlottetown; Hon.-Sec., Mrs. Don Wonnacott, P.E.I. Hospital, Charlottetown; Hon.-Treas., Mrs. John Cameron, Summerside; Chairmen of Committees; Nursing Education, Miss Bernice Rowland, Charlottetown; Nursing Service, Sister Mary Patricia, Charlottetown Hospital; Public Relations, Sister Mary David, Charlottetown Hospital; Legislation & By-Laws, Miss Verna Darrach, Charlottetown; Finance, Mrs. Lois MacDonald, P.E.I. Hospital, Charlottetown.

HELEN L. BOLGER R.N.
Executive Secretary
ASSOCIATION OF NURSES
OF PRINCE EDWARD ISLAND

Unknown Soldiers

Two more unknown American service men will be entombed in Arlington National Cemetery beside the Unknown Soldier of World War I.

A bill signed by President Eisenhower provides for the entombment on Memorial Day, May 30, 1958, of an unknown member of the armed forces who fell in World War II and an unknown soldier of the Korean conflict.

* * *

A man never knows what he can do until he tries to undo what he has done.

— FRANCES RODMAN

* * *

One hundred mistakes will give you an education — if you have learned something from each one of them.

no need to be

A W O L

Absent **W**ith **O**ut **L**ogic

By using TAMPAX intravaginal tampons, women in all walks of life usually find they can pursue their normal activities without interruption. The greater comfort, convenience, and safety of this improved method of menstrual hygiene has won the enthusiastic approval of nurses everywhere. Physicians too have found it highly satisfactory. The three TAMPAX absorbencies—Regular, Super, and Junior—provide individualized protection to meet varied absorption requirements.

COMFORTABLE — physically and psychologically

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SAFE — eliminates odor and irritation

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TAMPAX

the intravaginal menstrual guard of choice

Canadian Tampax Corporation Limited
Brampton, Ontario.

Shall appreciate samples.

R.N. _____

Address _____

City _____

Le Nursing à travers le pays

Congrès du Conseil International des Infirmières

Rome, du 27 mai au 1er juin 1957, recevra les 235 infirmières canadiennes qui iront participer au 11ième Congrès Quadriennal du C.I.I. Dès le début de 1956, les infirmières commençaient à s'inscrire pour ce congrès ce qui pouvait déjà laisser prévoir que le contingent canadien de 235 serait au complet.

Le programme, sujet à revision, a été remis à toutes les infirmières qui ont demandé d'être inscrites pour le congrès et en voici les grandes lignes:

Thème du Congrès: Responsabililté.

Assemblée du Grand Conseil le premier jour du Congrès (le conseil est formé des membres ayant droit de vote, les membres du Bureau des Directeurs et quatre déléguées de chaque Association membre actif).

Les trois derniers jours seront employés à la présentation de travaux et à des discussions sur les sujets suivants: Responsabilité dans le choix des étudiantes-infirmières; Responsabilité dans la formation de l'infirmière; Responsabilité dans l'administration d'un service de nursing.

Il nous fait plaisir d'annoncer que Mlle Helen Carpenter, professeur adjoint à l'Ecole d'Infirmières de l'Université de Toronto et deuxième vice-présidente de l'Association des Infirmières Canadiennes, représentera le Canada en présentant un travail sous le titre général: "Le rôle de l'infirmière dans l'ensemble du programme sanitaire." D'autres travaux seront présentés sur le même sujet par des personnes venant de Suède et d'Italie.

Les représentantes de l'A.I.C. seront notre présidente, Mlle T. Hunter et notre secrétaire-générale, Mlle P. Stiver.

Le Manuel des Comités

Afin de guider les convocatrices et les membres des comités nationaux, un manuel a récemment été distribué. Préparé au secrétariat national, le manuel des comités présente la structure des comités nationaux et spéciaux ainsi que des sous-comités, leurs fonctions, leurs membres, la préparation des procès-verbaux et des rapports.

En plus, on y trouve des renseignements concernant les voyages, l'aide que peut nous apporter le secrétariat national, ainsi que les règlements des cinq comités nationaux.

Ce manuel a été préparé en vue d'expliquer et de faciliter le travail de notre association mais il peut aussi être utile à d'autres groupes dont l'organisation et le fonctionnement sont semblables aux nôtres.

Pour faciliter le travail des comités, canaliser les renseignements et compiler les rapports, un guide est nécessaire. Un manuel, cependant, n'est pas à lui seul une garantie de succès qui ne sera assuré que par le travail consciencieux de chacun des membres des comités. Nous souhaitons aux 75 membres des comités de l'A.I.C. du succès pour la présente période biennale.

Programme d'Etudes de l'A.I.P.Q.

Ces dernières années, les comités du programme d'études de l'A.I.P.Q. français et anglais, ont travaillé à la revision du programme d'études à l'usage des écoles d'infirmières de cette province. En septembre, les directrices et les institutrices des écoles d'expression anglaise se sont réunies pendant trois jours pour examiner le travail déjà accompli et préparer une rédaction des principes susceptibles de déterminer le choix du programme clinique. Le résultat de cette conférence bien qu'encore incomplet laisse entrevoir qu'on semble s'éloigner de la tradition. Par suite de discussions longues et animées sur les connaissances générales que doit posséder l'étudiante avant de pouvoir donner des soins intelligents, il fut impossible de déterminer la matière du programme. Le Comité espère que de futures études et discussions permettront de déterminer les connaissances de base nécessaires à l'infirmière et d'éliminer du programme tout ce qui est inutile.

Le groupe français a fait en octobre la revision d'une partie du programme d'études mis à l'essai il y a déjà deux ans. Tenant compte des commentaires apportés par les diverses institutions, toutes les matières sont revisées à tour de rôle. Des experts, consultés au cours des séances d'études, ont aidé à l'élaboration d'un programme répondant aux besoins de notre temps.

Soins à domicile (1)

Depuis dix ans, on a constaté un intérêt croissant en faveur du soin des malades à domicile. Le grand nombre de personnes ayant besoin de soins prolongés, le coût

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Tetracycline *Lederle*

ACHROMYCIN is a true broad-spectrum antibiotic, effective against a wide variety of infections including those caused by Gram-positive and Gram-negative bacteria, rickettsiae, and certain viruses and protozoa.

It is rapidly absorbed and promptly produces high blood levels, thereby controlling infection quickly.

It is well tolerated by patients of every age, and the incidence of side reactions is negligible.

It is available in 21 dosage forms; the doctor can choose the one form best suited to the patient's needs.

Every gram of ACHROMYCIN is made in Lederle's own laboratory, and it is available only under the Lederle label—the doctor's assurance of highest quality.

Because of these important advantages, ACHROMYCIN is the most widely prescribed of all broad-spectrum antibiotics.

If you should like more information about this or any other Lederle product, speak to the Lederle representative.

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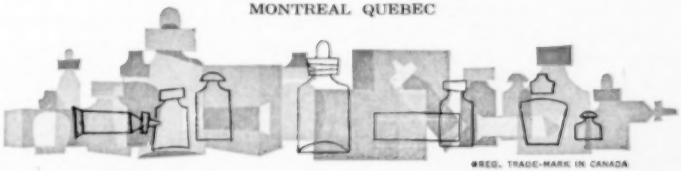

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élevé de l'hospitalisation et de la construction d'hôpitaux, le fait que l'on semble de plus en plus prendre conscience des effets préjudiciables que peut avoir un séjour prolongé dans les institutions ont contribué à accroitre cet intérêt.

Les plans de soins "hospitaliers" à domicile ont été inaugurés par le Montifiore Hospital, à New York, comme moyen de résoudre le problème de l'insuffisance du nombre de lits d'hôpitaux et de prendre soin des malades chroniques.

A Montréal, le Herbert Reddy Memorial Hospital institua en 1950 un plan de soins à domicile en collaboration avec le Victorian Order of Nurses. Le malade quitte l'hôpital plus tôt et passe à son foyer la période qui précède la complète convalescence. Les internes de l'hôpital visitent les malades sous la direction du médecin traitant à qui ils font rapport tout comme si le malade était encore à l'hôpital. Les soins sont donnés par les infirmières du V.O.N. L'infirmière fait ses rapports au département des soins à domicile de l'hôpital afin qu'un dossier complet soit à la disposition du médecin. Au point de vue du malade, ce plan a deux avantages: un retour précoce au foyer dans un milieu familial et une diminution marquée du coût de la maladie.

(1) U.S. Dept. of Health, Education & Welfare "A Study of Selected Home Care Programs" Public Health Monograph No. 35, Washington, D.C.

Initiatives

En février dernier, Mlle G. Sharpe, ancienne présidente de l'A.I.C. adressait la parole aux présidentes réunies pour la conférence du "National Council of Women." Son sujet fut: "Les plans de soins à domicile." A la suite de cette conférence, les comités de santé des conseils régionaux se proposent d'étudier cette année la possibilité d'établir des plans de soins à domicile dans les différentes villes du Canada.

A la Croix-Rouge Canadienne, sous la direction du Comité National du service du Nursing, un comité fut formé pour étudier les plans de soins à domicile à travers le Canada.

Education des Adultes

Qui peut s'intéresser davantage à l'éducation des adultes que l'infirmière? Chaque infirmière est un professeur de santé et elle est appelée de par sa fonction à enseigner à des personnes de tous âges, tout le long de sa carrière. C'est pour cette raison que l'A.I.C. est membre de Le Société Canadienne de l'Education des Adultes et participe à ses assemblées. Les relations de l'A.I.C. avec la Société lui fournissent maintes occasions de faire connaître les services d'infirmières ainsi que de tirer elle-même profit de l'expérience d'autres groupes.

Si quelqu'un est intéressé à devenir membre de la Société Canadienne de l'Education des Adultes, il peut s'adresser à 3425 rue St-Denis, Montréal.

Dis-moi ce que tu manges je te dirai qui tu es!

Une mauvaise alimentation est un problème que l'on rencontre dans presque toutes les familles canadiennes, quels qu'en soient les revenus. Il faut attribuer cette déficience à l'ignorance de la valeur des aliments et du rôle important qu'ils jouent dans la santé des individus.

Les infirmières, par leur contact direct avec les gens — au foyer, à l'hôpital ou au travail — sont dans une position des plus favorables pour enseigner la nutrition. Le contact personnel a beaucoup plus d'effet qu'une simple lecture.

Il existe cependant d'intéressants dépliants, brochures, etc. publiés par diverses organisations qui aideront l'infirmière à enseigner "ce qu'il faut manger pour être en santé."

Une liste de ces publications peut être obtenue de l'A.I.C. Une enveloppe contenant un groupe de ces diverses publications sera prêtée à qui en fera la demande.

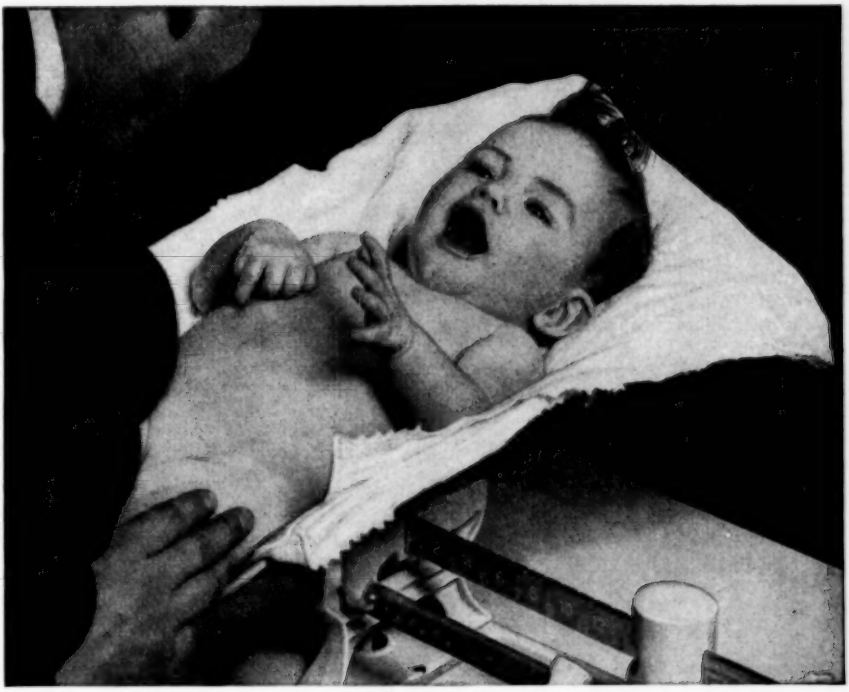
Quelles nouvelles à l'A.I.C.?

L'A.B.C. de l'A.I.C.! C'est un feuillet miméographié donnant des renseignements de la dernière heure sur les membres, l'emploi des infirmières, la composition du comité exécutif et des comités nationaux et la liste des associations au bureau de direction desquelles l'A.I.C. est représentée.

Publications de l'A.I.C. Un autre feuillet donnant la liste de toutes les publications que l'on peut se procurer au secrétariat national.

Dans les deux cas, s'adresser à L'Association des Infirmières Canadiennes 270 ouest avenue Laurier, Ottawa, Ont.

More than 100 000 displaced persons have been reunited with relatives since World War II through the efforts of the International Committee of the Red Cross, the Committee announced recently.



"Infants fed meat under 2 months of age . . . improvement in physical growth."

Jacobs & George in "Evaluation of Meat in the Infant Diet," Pediatrics, 10,463 (1952) report that there was an improvement in physical growth as determined by weight and height measurement in infants first fed meat under two months of age. The same group demonstrated an improvement in hemoglobin levels; the elimination of the physiologic drop in total protein levels of the serum, with a prompt sustained rise in values, the greater part of which was composed of the globulin fraction.

Swift's produce eight kinds of Meats for Babies for variety and for special nutritional benefits—beef, lamb, pork, veal, liver, heart, liver and bacon, strained chicken and Egg Yolks for Babies and Salmon Seafood. Also Chopped Meats for Juniors with a texture of sufficient coarseness to help children adapt easily and gradually to table foods.

Recommend with confidence Swift's Meats for Babies and for Juniors.

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most precious product

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To Serve Your Family Better

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Book Reviews

Truth About Cancer, by Charles S. Cameron, M.D., Medical and Scientific Director, American Cancer Society. 257 pages. Prentice-Hall, Inc. Publishers, 70 Fifth Avenue, N.Y., 1956. Price $4.95.

Reviewed by Dr. H. S. Morton, Central Tumor Registry, Royal Victoria Hospital, Montreal.

The "Truth About Cancer" is a dramatic and an accurate description of the story of cancer at the present time. With clear and concise definitions, the picture is vividly presented.

The first part of the book consists of a general review of the whole situation and is excellent, particularly the chapters on cause, misconceptions, diagnosis, treatment, quacks and research. The account of incidence is naturally weak because on this continent so little is known about incidence. This is one of the greatest weaknesses in the present attack on this group of diseases.

The second part of the book called "A Closer Look at the Different Anatomical Sites" gives a fairly detailed description of these in simple terms.

This volume, sponsored by the American Cancer Society and written by its medical and scientific director, is an able straightforward attack on this major problem.

Aids to Surgical Nursing, by Katherine F. Armstrong, S.R.N., S.C.M., D.N. (Lond.). 432 pages. The Macmillan Company of Canada Limited, 70 Bond Street, Toronto 2, Ont. 5th Ed. 1954. Price $1.00.

Review by Miss Anne Fallis, Calgary General Hospital, Calgary, Alta.

This is one of "The Nurses' Aid Series," small handbooks that can be easily carried for ready reference, at a price any nurse can afford.

It contains such information in relation to general surgery as: the basic knowledge on which surgery is based, complications of, preparation for and detail concerning specific surgical conditions. Reference is made to the newer methods in heart operations and in sympathectomy. It does not include the surgical treatment of varicosed veins. Approximately 50 pages are devoted to fractures which seems a rather high proportion in a book of this size. It does not contain details of nursing procedures, gynecological surgery or surgery of the eye, ear, nose and throat which are in separate volumes.

It is clearly and concisely written, often in point form. As this is a British book, there are differences in the use of terms, i.e. fomentations for sterile compresses, and in the names of drugs in use. For this reason the graduate or senior student will find it a useful reference, but not the junior student who has not learned to make adaptations.

Principles and Techniques of Psychiatric Nursing, by Madelene Elliott Ingram, R.N. 529 pages. W. B. Saunders Company, Philadelphia and London. 4th ed. 1955 Price $4.75.

Reviewed by Sister Thomas Joseph, Halifax Infirmary, Halifax, N.S.

This revised textbook should be warmly received by those seeking a means of introducing the student to the "how" and "why" of psychiatric nursing. The author is to be commended for placing a much needed emphasis on the student "relating the patient to the environment rather than the reverse."

The dynamic approach to the clinical situation should aid the student to assume her role as a teacher and leader, as well as to acquire the technical skill and understanding required of a good psychiatric nurse.

The illustrative figures throughout the book, the various case histories and problem-solving situations followed by the student's critical appraisal will be of incalculable value to the teacher.

Exception might be taken to the interpretation of various religious viewpoints expressed in Unit I, which gives a brief but concise history of nursing.

One concludes the reading of this text in complete accord with the author's opinion that knowledge of advanced theory in itself does not make an "advanced" psychiatric nurse.

* * *

In a free democracy it is essential that each man have an understanding of himself and of his job in its context. He must know enough about his society to act as an intelligent citizen in it; and he should be familiiar enough with its culture to be able to make intelligent individual choices in life.

— Oscar Handlin

* * *

The greatest thing in this world is not so much where we stand, as in what direction we are moving. — Oliver W. Holmes

Confirmed again clinically[1] the remarkable

safety-efficiency

record in relief of

constipation

and teething

gastrointestinal upset and malaise

Baby's Own Tablets

Extensive newly completed studies verify the outstanding safety record and the efficiency of BABY'S OWN TABLETS. Patients ranged in age from 2 months to 24 months.

One large group of infants suffered constipation, another group intestinal disturbances and malaise, coincident with teething.

The result from the studies were as follows . . .

ALL CONSTIPATED BABIES were relieved with complete easing of straining at stool, gas discomfort, restlessness and crankiness.

ALL TEETHING BABIES suffering concomitant gastrointestinal disturbances and malaise were relieved except one. Disturbed sleep, restlessness, crankiness were relieved as well as anorexia and constipation when present.

EMINENTLY SAFE — "Throughout the study . . . in no instance was there any untoward reaction; no cutaneous eruptions or other allergic manifestations, no petechiae, no rise in rectal temperature, no alteration in cardiac and respiratory function, no vomiting or diarrhea, no oliguria, no albuminuria. No significant changes were observed in weight, growth, development or hemoglobin before and after the period of medication."

Pleasant, convenient BABY'S OWN TABLETS provide Phenolphthalein 3/16 grain, mildly buffered with Precipitated Calcium Carbonate ½ grain, and Powdered Sugar q.s.

Send for a sample supply and literature citing references.[1-12]

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Sélection

Les préjugés

Avant de faire un stage en psychiatrie, j'avais, comme tout le monde ou à peu près, des préjugés concernant les maladies mentales. Je croyais lorsqu'on amenait quelqu'un dans un hôpital psychiatrique, que c'était nécessairement un grand agité. J'ai, par les nombreux cours que nous avons suivis, beaucoup appris au sujet de maladies et de techniques inconnues auparavant. Les malades que nous avons soignés dans les départements nous ont permis une application pratique de ces cours.

Si une personne de mes proches tombait malade et était hospitalisée dans une de ces institutions, mes parents seraient bien peinés et la prendraient en pitié mais je crois qu'ils essaieraient de cacher autant que possible son état à l'entourage.

La cerveau étant la partie noble du corps de l'homme, son atteinte parait plus grave. Personne ne veut avouer qu'il n'a pas la tête bien solide et c'est probablement pour cela qu'il est difficile d'abolir les préjugés vis-à-vis ces maladies.

Souvent les parents d'un malade s'objectent lorsqu'il est nécessaire d'avoir recours à un psychiatre; alors, il faut leur démontrer par plusieurs exemples que les maladies mentales, prises à point, guérissent. Voyant ainsi la possibilité d'une guérison, ils accepteront peut-être plus voluntiers l'hospitalisation du malade. Il faut qu'ils comprennent qu'il n'est pas plus honteux d'être atteint d'une maladie mentale que d'être cardiaque ou tuberculeux.

Les maladies mentales guérissent si on les prend au début; elles restent stables ou empirent lorsqu'on les soigne trop tard. Grâce à tous les traitements que l'on trouve dans un hôpital psychiatrique: insuline, électrochoc, psycho-thérapie, médication, les malades s'améliorent nécessairement. Toutefois, il est bon que le patient change de milieu lorsqu'il sort de l'hôpital car le milieu influe énormément sur toute personne. Prenons un cardiaque hospitalisé à la suite d'une crise, s'il retourne dans la même vie agitée, il pourrait bien faire une nouvelle crise qui lui sera peut-être fatale.

Le fait d'avoir été hospitalisé ne constitue pas, en soi, une tare; cela peut arriver à des gens de tous les milieux et de toute profession. J'accepterais bien volontiers de travailler avec un ancien malade mental mais je prendrais quand même quelques précautions élémentaires. En apprenant à la suite de quels événements la maladie a débuté, je m'efforcerais d'éviter à cet ancien malade les situations susceptibles de l'affecter.

Mon stage m'a été bien profitable, car j'ai pu observer tous les traitements qui se donnent et les résultats obtenus. Dans une période d'un mois et demi, j'ai déjà vu plusieurs de mes patients qui sont retournés chez eux guéris. N'est-ce pas là un encouragement pour les malades et une satisfaction pour ceuà qui leur donnent des soins?

Extrait de *Sentinelle*, journal des étudiantes-infirmières de l'Hôpital St-Jean, Saint-Jean, P.Q.

In muscular dystrophy, extensive studies have detected an error in protein metabolism. It has been learned that oxyproteic acid is not metabolized properly in patients. Researchers are now trying to determine if this is a cause or an effect of the disease. — *Scope Weekly*

News Notes

ALBERTA

District 2

Camrose

Mrs. Hardnut, chapter delegate to the CNA convention in Winnipeg gave a very interesting and comprehensive report at the well attended September meeting. To augment the Bursary Fund the annual Nightingale Dance was scheduled for the end of October.

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Ponoka

A well attended meeting on September 19 opened the fall activities when Mrs. E. Coombs was elected the new president of the district association. An interesting program was provided by one of the members who recently visited Denmark and took many pictures. The very pleasant evening ended on the right note for the hunting season! Roast duck with all the delicious trimmings was served.

District 3

Banff

Attendance at the Baby Clinic, sponsored by the Chapter, has grown to such an extent that larger accommodation in the school auditorium has been secured.

At a small tea at Mrs. Gourlay's home the bursary awarded to Zona Paris of Banff was presented together with a lovely book of mountain paintings. Zona is now enjoying her new life at the University Hospital, Edmonton.

An "Autumn Ball" sponsored by the Federal Employees' Recreational Society was well attended. The proceeds were given to assist the chapter's Children's ward project.

Miss I Krandel, public health nurse with the Morley Indian Reserve gave a lively and informative talk on the trials and satisfactions of working among the Indians.

Calgary

Forty members participated in the supper meeting which marked the annual district gathering. A report of the Biennial convention was given by L. Bibby. The slate of officers for the coming year was elected.

District 4

Provost

A film depicting the surgical repair of patent ductus arteriosus highlighted the September chapter meeting. Eleven members were in attendance.

District 6

Red Deer

D. Hilsabeck of Clive was the successful candidate for the $300 chapter scholarship given to assist a girl to obtain her professional training. A social gathering and "pretaining" shower was held at the home of Lady Stonehouse as part of the presentation ceremony.

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DISTRICT 7

EDMONTON

The district association approved affiliation with the Local Council of Women, at its business meeting in October. The program featured a panel discussion on student nurse recruitment under the title "Interesting Nurses." Miss J. Clark was chairman with Shirley Stinson, Mrs. Peggy Marko and Floreen Sydorchuk, a third year student, participating.

STONY PLAIN

Mr. A. Miller, legal adviser to the A.A. R.N. spoke on the Legal Aspects of Nursing at a recent chapter meeting. An interesting period of discussion followed the address. Mr. A. Yuhem will conduct a course in first aid.

DISTRICT 8

PINCHER CREEK

Chapter members assisted with a tag day for St. John's Ambulance early in October. Plans are underway for a gala Christmas party.

BRITISH COLUMBIA

CARIBOO DISTRICT

Mrs. Winifred Warner of Prince George was elected president of the district at the annual meeting held in Quesnel the end of September. Miss A. Wright, provincial executive secretary, was guest speaker and described her trip to Denmark last spring, illustrating her talk with many interesting slides she had taken. Mrs. Len Taylor was hostess for a coffee party following the meeting.

QUESNEL

At the October chapter meeting a letter of appreciation was read from Joy Leake of Nazko who was winner of this year's Bursary award. She entered the school of nursing of Vancouver General Hospital in September. Bursary winners will be remembered, henceforth, with a small financial gift at Easter during their second and third years in training.

CHILLIWACK

Forty-two members attended the annual dinner meeting of the chapter. The guest speaker was Miss Trenna Hunter, president

of the CNA. A gift was presented to her on behalf of the members in token of their appreciation. A doll drawing is to be held this month with proceeds being used for furnishings for a ward in the new hospital wing. A jewellery and clothing drive is to be held for the Crease Clinic and Provincial Mental Hospital, Essondale.

PENTICTON

At the September meeting, with Mrs. Innes Brown presiding, Mrs. Verna Crittenden presented an interesting report of the 28th Biennial Convention and showed pictures she had taken on her trip. Mrs. Crittenden was named convener of the special committee to arrange for the annual meeting of Kamloops-Okanagan District that will be held here.

At the October meeting, two surgical films — Halstead operation for carcinoma of the breast and one-stage total colectomy for ulcerative colitis evoked great interest.

VANCOUVER

St. Paul's Hospital

A homecoming was held in mid-October with members of the classes of '21 and '22 as honored guests. A short program preceded an evening of visiting and renewing acquaintances. In November a fashion show and sale of work proved successful, with a cocktail dress being presented to the winner of the door prize.

C. Guimont and S. Warren who have been nursing with the Suez Contractors Service have returned to England due to the political situation. L. Belecky has joined the staff of Woodwards Stores. D. (Boden) Coombes has gone to Bedfordshire, England. Sister Charles and Sister Elie celebrated their 50th anniversary as members of the sisterhood in August. Sister Denise Margaret is on the staff of the new hospital at McLellan, Alta.

MANITOBA

HAMIOTA

Local nurses were hostesses at the first general meeting of District 2 early in October. Thirty-five members were in attendance with Mrs. Jean Fargey presiding. A group led by P. Long presented a series of reports from the 28th Biennial Convention. Miss M. Dunn, matron of the local hospital, conducted a tour of the building. At the November meeting which was held in the Hospital for Mental Diseases, Brandon. Miss Lillian Pettigrew addressed the members on "The Registered Nurses' Act and Bylaws."

WINNIPEG

General Hospital

The first meeting of the season for the alumnae association was held in the auditorium of the nurses' residence. To com-

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memorate the Golden Jubilee of the association which occurs in 1957, Miss Ethel Johns was asked to write the history of the school. This book is almost ready to go to press. After 28 years with the hospital, fourteen of which were spent as superintendent, Dr. H. Coppinger has retired. A number of social events marked this occasion.

NOVA SCOTIA

Miss Joan Palmer, who took her public health nursing at McGill University, joined the staff of the Department of Public Health in 1951. Miss Palmer remained on the staff as public health nurse in Shelburne until recently. She has been granted leave of absence to take a course in administration and supervision at McGill University.

Miss Margaret Masters, nursing consultant in the Child and Maternal Health Division for the Province of Nova Scotia resigned her position as of September 21 to accept a position at the Jewish General Hospital, Montreal, teaching student nurses.

Miss Mary MacSephney who took her basic public health at Dalhousie University 1953-54, and then worked on the staff of the Department of Public Health from the Tatamagouche district until July of this year, at which time she was transferred to the Truro office, has been granted a year's leave of absence to take a course in administration and supervision at the University of Toronto.

ONTARIO

District 5

Toronto Western Hospital

The fall general meeting of the Alumnae Association was held early in October. The guest speaker was Miss D. McGeachy, who gave an interesting account of her work in the newly acquired Speech Clinic.

The Class of 1931 held their 25th Anniversary reunion dinner at the hospital early in June. Guests of honor at the dinner were Miss Beatrice Ellis and many of the class teachers and supervisors. Following a tour of the hospital, the new educational building and the Archives, the class attended a party at the Seaway Hotel to complete a most enjoyable weekend.

Miss Margaret McKenzie was recently on six weeks' leave of absence from her position with the World Health Organization, near Calcutta, India, where she is enjoying her work in public health. Sona Canara has been appointed as nursing superintendent of the United Church of Canada Hospital, Mandlesharwar, India. Jean Craig is working at the Leslie Hospital in Honolulu. Betty McKay is attending McGill University. Miss Kathleen Peebles and Miss W. Bartolicies are busy at University of Toronto. Florence Inch has recently been appointed head nurse on 5 East, after having completed a postgraduate course in obstetrics at the Chicago Lying-in Hospital. D. Hall has recently joined the staff as an instructor in the surgical department.

District 7

Kingston

The Ontario Hospital

Graduation exercises took place on September 21 when 16 nurses received their pins and diplomas. The guest speaker was Professor A. Edinborough, editor of *Whig-Standard*. The prize for Anatomy and Physiology, donated by the Nurses' Alumnae, is to be an annual award.

The graduating class were entertained by Dr. and Mrs. C. H. McCuaig, Dr. and Mrs. E. A. James, Dr. and Mrs. Henry Shaffer, Mrs. T. Ferguson, Ontario Hospital nursing office and supervisors. The Alumnae also entertained them at a dinner and presented each with a year's membership in the Association and a gift of a crystal vase.

Church service for the graduating class was held Sunday, September 16, at St. John's Anglican Church, conducted by Canon Minto Swan. The choir entertained following the service.

On September 28, 1956, the corner stone was laid by Hon. Wm. Nickle for the new 500-bed addition and administration building. Miss E. G. Smith, superintendent of nurses placed the documentary box in the cornerstone. It is expected that this new addition will be open in the Fall of 1957.

Miss Florence Latimer, assistant superintendent of nurses, attended the Biennial Convention in Winnipeg this year.

Several changes have taken place in the nursing staff: Miss A. Ladas is touring Europe and Miss L. Legge, B.N.Sc., is in charge of the affiliation program; Miss S. Potter, B.N.Sc., is our new science instructor and Mrs. M. Fooks our health instructor. Mrs. D. Ferguson and Miss H. Zarins entered Queen's University in September to take teaching and supervision.

District 8

Ottawa

Civic Hospital

The alumnae's annual tea and bazaar was held on November 2. A special feature was the "Post Office" table where unopened gift parcels were eagerly sought at 25 cents each.

A gift of opera glasses was presented to Effie McIlraith whose departure was marked at a tea in early May.

The fifth bursary-loan award was made to Irene Clarke, '54, who is majoring in public health nursing at the University of Western Ontario this year.

An alumnae chapter was formed in Toronto recently. Any O.C.H. graduates in that vicinity are asked to get in touch with Mrs. D. Piercey, 122 Norsemen St., Islington.

General Hospital

Members of the graduating class were

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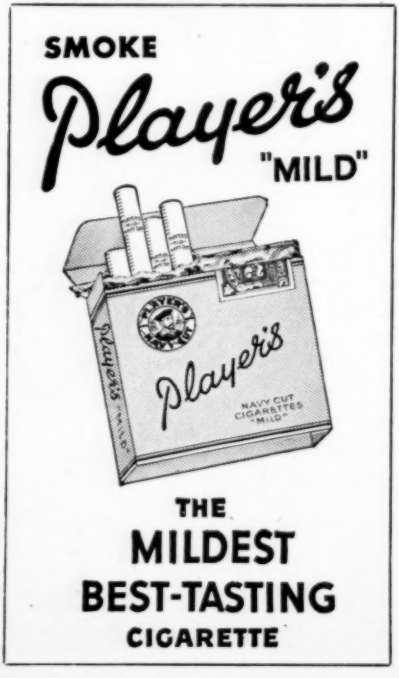


guests of honor at a banquet held in September. Approximately 150 alumnae members and guests attended. Miss C. Casey, a graduate of 50 years ago, was presented with a scroll and life membership. The classes of '26, '31, and '46 took this opportunity to hold reunions. Mrs. O. Stewart convened arrangements for the dinner assisted by Mrs. A. Hobbs and Sister Madeleine of Jesus.

PRINCE EDWARD ISLAND

Charlottetown

Charlottetown Hospital

In September, alumnae members observed the 25th anniversary of their association. Almost every class from 1923 to 1956 was represented at the banquet. An honored guest was Miss Mae King — a member of the first graduating class and the first president of the alumnae association. During the evening pictures of each graduating class were shown while Mrs. H. Murphy related in verse humorous anecdotes of training experiences. Later, alumnae members were joined by their husbands and friends for dancing. Approximately 100 religious and lay nurses shared the day's activities commemorating this occasion.

QUEBEC

District 9

Quebec City

Jeffery Hale's Hospital

J. Radley Walters is attending the School for Graduate Nurses, McGill University, enrolled in the teaching course in medical and surgical nursing. A. MacDonald is doing postgraduate study in obstetrics and gynecology in the Royal Victoria Montreal Maternity Hospital. S. Grey has joined the staff of the Polyclinic, New York City.

District 11

Montreal

The Montreal General Hospital

All year we have been looking forward to celebrating our 50th anniversary which was deferred for one year at the request of the medical staff, so that our celebration would coincide with the medical staff reunion. The dates selected were September 20, 21 and 22, 1956 — three red-letter days in the history of our alumnae.

The air of expectancy and excitement reached its peak on the morning of September 20. The final preparations were completed so we were ready to enjoy our get-together.

September 20 dawned dull and misty to the great disappointment of our ardent alumnae and hospital staff but our prayers were answered and the weather cleared. By 9:00 a.m. the sun was shining and a huge

crowd had gathered in the main entrance of the hospital where each member registered. People assembled in constantly changing groups where news was exchanged and greetings extended. Members had come from all across Canada, from the Atlantic to the Pacific. Gradually the crowd sorted itself out to attend the tours, lectures and demonstrations.

At 3:30 p.m. slightly tired but still full of enthusiasm, the crowd arrived in Livingston Hall for tea. It was a great success. The home never looked nicer, decorated with a profusion of roses and autumn flowers. More than ever we realized we were members of one big family. The sentiment and feeling towards The Montreal General Hospital still lives today in the new buildings. It was demonstrated by the enthusiastic gathering that the spirit of the members makes an institution what it is. Bricks and mortar are insignificant. The feeling of pride at belonging to such a united group influenced most members to enter into conversation with whoever happened to come near. In short, it was a very gay and friendly tea party.

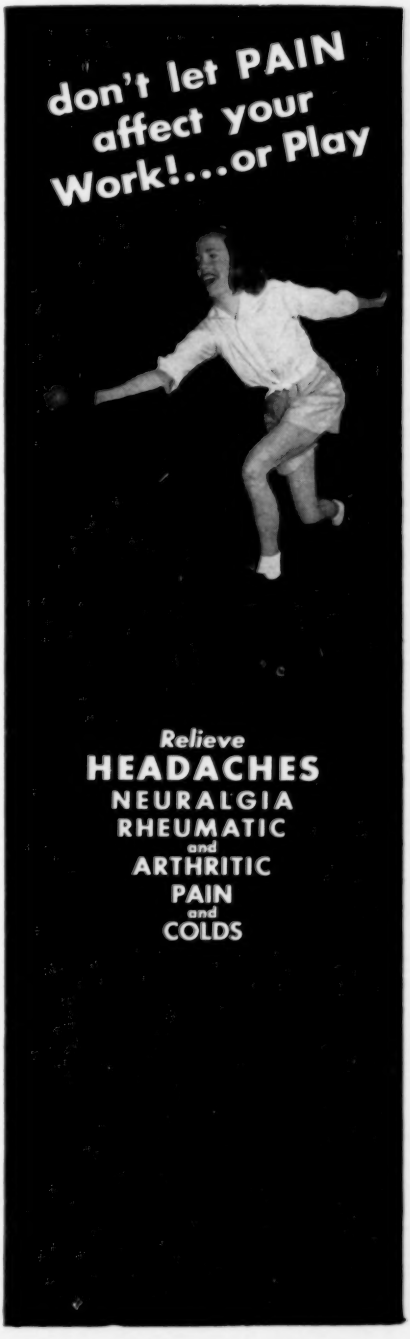
We had to bid hasty au revoirs to get ready for the dinner at the Windsor Hotel. Here, the increase over the numbers expected delayed proceedings for a while. It was welcomed; more visiting together could be done. It was during these chats that many private class parties were arranged. This increased the reunion's popularity.

The dinner was attended by 500 members. The highlight of the evening was the speech by Miss M. J. Denniston, director of nursing of Methodist Hospital and Blank Memorial Hospital in Des Moines, Iowa. Miss Denniston graduated from The Montreal General Hospital with the class of 1929. All the outstanding characters in the old General, (while she was there) from the highest to the lowest were included in her witty talk, to the delight of the audience. Then she passed along to the present day with our modern devices and philosophies. No one could have bridged the gap between the old and the new more effectively than Miss Denniston. When we sang Auld Lang Syne, it was a happy ending to a very full day.

Friday, the doctors' wives sponsored a luncheon and fashion show in the Mount Royal Hotel which was attended by a capacity crowd. Here again, one heard the greetings and gay conversation of friends meeting after many years of separation. This was a gala occasion enjoyed by everyone. On the same day in the afternoon the doctors' wives and nurses shared tea and reminiscences at the Museum of Fine Arts.

Saturday dawned with beautiful bright sunshine. The crowd had begun to thin out and it was with a feeling of nostalgia that we attended the football game at Molson's Stadium. Excitement kept our spirits up till the end of the game when we said goodbye to our friends.

Looking back on those three days, nothing could have done more to make our alumnae realize that the new building is really The Montreal General Hospital regardless of its situation and modern decor. The old feeling



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of loyalty to tradition tempered with progressive enthusiasm still prevails.

Royal Victoria Hospital

At the October meeting of the alumnae Mrs. Scrimger gave a description of her trip to England last June to attend the Victoria Cross Centenary Celebration. Miss Mary Warnock, who had attended the CNA convention in Winnipeg as the alumnae's representative, gave a report of the business conducted there.

Edith Green has completed her tour of duty with World Health Organization in Alexandria, Egypt, and has returned to Victoria, B.C. B. Locke and I. Rimstead are on the staff of King Edward VII Memorial Hospital in Bermuda.

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SASKATCHEWAN

PRINCE ALBERT

The chapter meets on the first Monday of each month throughout the year excepting July and August. These meetings alternate between the Victoria Hospital, The Holy Family Hospital, and the Prince Albert Sanatorium. At the close of each meeting the staff of the hospital serves refreshments.

The project of the chapter is to supply cod liver oil to needy children of the city. To raise funds for this purpose we have been sponsoring an annual dance, conducting rummage sales and each member is expected to contribute at least $2.00 during the year in talent money.

The executive officers for 1956 are: President, Mrs. Elsie Tundall; secretary, Mrs. Marg. McConechy; treasurer, Mrs. Edith Lewis.

Special items on the program for the September and October meetings consisted of the reports on the Biennial meeting of the CNA in Winnipeg, by the chapter delegates, Miss Eveline Nicol and Mrs. E. Sanders.

Business discussed at these meetings covered ways and means of raising money. At the October meeting, Miss Vera Spencer, Mrs. Beth Meleike, and Mrs. E. Sanders volunteered to act on a committee to revise the bylaws to conform to the provincial bylaws with regard to committee formation.

A committee consisting of Miss E. Nicol, Mrs. H. G. Pond and Mrs. Jean Harry was formed to arrange for a bake sale.

SASKATOON

City Hospital

Mrs. Dorothy Parkinson, president, welcomed throngs of guests to the alumnae Chapel Fund tea and bazaar held in mid-September. Mesdames J. D. McNelles and J. Tait were co-conveners of this popular social function that was a great success financially netting a considerable addition to the fund that will be used to assist in building a chapel at the hospital for the use of both patients and staff. While tea was being served models from the Hudson's Bay Company strolled through the crowd displaying smart afternoon and street apparel. The "Parcel Post" table was piled with packages received from graduates all across Canada.

St. Paul's Hospital

Approximately 150 student nurses attended a special meeting in September when Miss Margaret Kerr, editor of *The Canadian Nurse* was guest speaker. Miss Kerr emphasized the part a professional journal can and should play in a student's progress toward her goal of becoming a truly professional nurse. The students were urged to write articles, descriptive of the care of patients, for publication.

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Hospital Superintendent & Director of Nurses (Combined) for 35-bed hospital fully accreditted. Good salary. Excellent living quarters. Apply stating references & experience to Chairman, Board of Directors, Fishermen's Memorial Hospital, Box 600, Lunenburg, N.S.

Superintendent of Nurses for 22-bed hospital. Good salary offered. Increments every 6 mo. for 3 yrs. Living accommodation in separate modern nurses' residence. Home equipped with automatic heating & hot water. 1 mo. vacation after 1 yr. employment. Statutory holidays extra. Cumulative sick leave to 90 days. No business matters to handle such as book-keeping, purchasing, admissions, collection of accounts. Apply in writing or phone Sec.-Manager, Union Hospital, Hafford, Sask.

Director of Nurses for 250-bed hospital with school of nursing. Suite in nurses' residence, full maintenance. Good personnel policies. Apply, stating salary expected, age, qualifications, training & experience to Administrator, Union Hospital, Moose Jaw, Sask.

Director of Nursing for 185-bed JCAH accredited General Hospital. Protestant Church affiliated. NLN temporary accredited school of nursing, 75 students. Addition to hospital under construction. Must have B.S. degree in nursing & preferably an M.A. in nursing. Good salary, furnished apt., position open early winter. Apply Administrator, Evangelical Deaconess Hospital, 3245 E. Jefferson Ave., Detroit 7, Michigan.

Assistant Director of Nursing for 800-bed General Hospital with 200-student school of nursing. University education required. Salary depends upon qualifications & experience. Apply to Chairman of Board, Royal Alexandra Hospital, Edmonton, Alberta.

Assistant Director of Nursing. Head Nurse, General Duty Nurses for 150-bed Hospital. 44-hr. wk. 31-days vacation plus statutory holidays, 2-wks. sick leave yearly. Write stating qualifications, salary expected, age & references to Director of Nursing, Grace Dart Hospital, 6085 Sherbrooke St. E., Montreal, Que.

Supervisor of Nursing Service for 50-bed active General Hospital. Salary: $210 plus maintenance with 6 monthly bonuses of 5%. 44-hr. wk. 10 statutory holidays & after 1 yr. on staff vacation of 21 days & sick time allowance of 14 days. For further information apply Miss M. Jarvis, Matron, Municipal Hospital Dist. #17, Wainwright, Alta.

Supervisor of Nursing (R.N. experienced in nursing service administration desirable) for new modern 50-bed General Hospital in progressive town (10,000) in Cariboo Dist. central B.C. 14 R.N.'s., 10 Aides, 6 Med. staff. Priv. suite in new residence. Salary commensurate with qualifications. 40-hr. wk., 28 days vacation plus 10 statutory holidays. Sick leave. Travel allowance. Please state age, salary expected, experience & references to Administrator, G. R. Baker Memorial Hospital, Quesnel, B.C.

Obstetrical Supervisor, General Duty Nurses (Immediately) for 40-bed General Hospital. Good salary & personnel policies. Living accommodations available. Apply Supt., Queens General Hospital, Liverpool, Nova Scotia.

Supervisors & Staff Nurses. Good salary & personnel policies. Living accommodations available. Apply Director of Nurses, General Hospital, Parry Sound, Ontario.

Night Supervisor, Assistant Head Nurses & Staff Nurses. Excellent personnel policies. Apply Director, Shriner's Hospital for Crippled Children, 1529 Cedar Ave., Montreal, Que.

Operating Room Supervisor for 118-bed General Hospital, located in a beautiful residential suburb along the North Shore of Chicago. Modern ranch style nurses' homes with attractively furnished private bedrooms. 40-hr. wk. Apply Director of Nursing Services, Highland Park Hospital Foundation, Highland Park, Illinois.

Clinical Instructor & Operating Room Nurse for 75-bed hospital with small school of nursing. Apply to Superintendent, Carleton Memorial Hospital, Woodstock, New Brunswick.

Instructor for school of nursing — Applications are invited for 138-bed hospital. This school is affiliated with Montreal hospitals, the teaching schools associated with McGill University. For particulars apply Matron, King Edward VII Memorial Hospital, Bermuda.

Assistant Head Nurses & General Duty Nurses for 150-bed Communicable Disease Hospital. Apply Director of Nursing, Alexandra Hospital, Montreal, Que.

Registered Nurses or Non-Registered Nurses if recent graduates (4) for very active 50-bed hospital. Salary: $180-$185 depending on experience, plus complete maintenance & laundering of uniforms. $5.00 increase every 6 mo. to a maximum of $200 & 5% bonus every 6 mo. 88-hr. fortnight with rotating 8-hr. shifts. 10 statutory holidays & after 1 yr. on staff vacation of 21 days & sick time allowance of 14 days. For further information apply Miss M. Jarvis, Matron, Municipal Hospital District #17, Wainwright, Alta.

Registered Nurse for 36-bed hospital. Starting salary: $205 per mo. Blue Cross benefits, sick leave etc. Apply Superintendent of Nurses, Hospital District No. 24, Box 330, Altona, Manitoba.

Registered Nurses. Single room residence. $225 per mo. gross. 5 day wk. 20 mi. east of Toronto. Apply Supt. Ajax & Pickering General Hospital, Ajax, Ont.

Registered Nurses. Gross salary for nurses currently registered in Ont. $235 per mo. Good personnel policies. New facilities. Comfortable nurses' residence. 8-hr. rotating shift. 44-hr. wk. 1 day off 1 wk., 2 the next. 1½ days holiday allowed per mo. same sick time accumulated to 90 days. 8 legal holidays per yr. The equivalent of single train fare paid up to $40 after 1 yr. service. Apply Supt., Lady Minto Hospital, Cochrane, Ont.

McKellar General Hospital, Fort William, Ont., requires **Registered General Duty Nurses.** Good personnel policies. Residence accommodation available at reasonable rates. Hospital has recently completed a well equipped & staffed wing with extensive renovation program progressing in the old section. Apply Director of Nursing.

Registered Nurses for General Duty. Initial salary: $200 per mo.; with 6 or more months Psychiatric experience, $210 per mo. Salary increase at end of 1 yr. 44-hr. wk.; 8 statutory holidays, annual vacation with pay. Living accommodation if desired. For further information apply Supt. of Nurses, Homewood Sanitarium, Guelph, Ont.

Registered General Duty Nurses for active 300-bed hospital. Starting salary: $210 per mo., 2 annual increases. 30 days vacation per yr. 8 statutory holidays. 44-hr. wk. Transportation refunded up to $50 after 1 yr. service. Accommodation available in new nurses' residence, if desired. Apply Director of Nursing Service, The General Hospital, Port Arthur, Ont.

Registered General Duty Nurses for 200-bed General Hospital. Salary: $200 per mo. 5½ day wk. Good personnel policies. Apply Director of Nursing, General Hospital, Sault Ste. Marie, Ontario.

Registered General Duty Nurses for County Hospital in Huntingdon, 45 mi. from center of Montreal. Excellent bus service. Pleasant working conditions. Nurses' home attached to hospital. Attractive community social life. 8 theatres, bowling, curling & dancing. 8 mi. from summer resort on Lake St. Francis & 12 mi. from U.S. border. Gross salary: $200 per mo. Three $5.00 increases at 6-mo. intervals to maximum $215. 44-hr. wk., 8-hr. duty, rotating shifts. Full maintenance available at $35 per mo. 2-wk. sick leave. Blue Cross paid. 1 mo. annual vacation, all statutory holidays. Apply Mrs. M. G. Curran, R.N., County Hospital, Huntingdon, Que.

Registered Nurses for modern 60-bed General Hospital situated 40 mi. south of Montreal. Salary: $200 per mo., additional monthly bonus for permanent evening & night shifts. 44-hr. wk., 8-hr. duty. Many attractive benefits provided. Board & accommodation available at minimum cost in completely new motel-style nurses' residence. Apply Supt., Barrie Memorial Hospital, Ormstown, Que.

Registered Nurses for private psychiatric hospital for intensive treatment, 20 mi. from New York City. Starting salary: $68 for 40-hr. wk. including regular pay increases, meals, laundry, hospitalization, yearly bonus. Differential for evening & night shifts. Paid vacation, 9 holidays, 14 days sick leave. Living accommodation, $5.00 weekly. Write giving qualifications to Miss M. Kennedy, Director of Nurses, Fair Oaks Inc., 19 Prospect St., Summit, New Jersey.

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A Naval Nurse is an important nurse — caring for the health of Canada's fighting sailors.

She leads an eventful life — with opportunities to engage in special fields, both medical and surgical and others — to travel — to serve her country — to enjoy the status and privileges of an Officer in Canada's senior service.

Our expanding Navy has openings now in its Nursing Service — for provincially-registered graduate nurses who are Canadian citizens or British subjects, single and under 35 years of age.

Apply today! Upon entry you will be offered a permanent or short service commission with officer pay, allowance for uniforms, full maintenance and other benefits including 30 days annual leave with pay and full medical and dental care.

As a Naval Nurse, you'll find real opportunity to advance in your profession! For full information apply to:

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NAVAL HEADQUARTERS, OTTAWA
or
YOUR NEAREST NAVAL RECRUITING OFFICE

CN-12-56

Royal Canadian Navy

Registered Nurses for modern 52-bed hospital in English speaking community, 50 mi. from Ottawa .Salary: $175 per mo. $5.00 extra for night duty (3 wks.). 44-hr. wk. 8 hr. duty full maintenance. Sick leave & annual leave. Fare advanced if required. Apply Supt., Pontiac Community Hospital, Shawville, Que.

Registered Nurses for 8-bed hospital. Straight 8-hr. shift. Gross salary: $240-$260 depending on experience. For further information apply Sr. Superior, Notre Dame Hospital, Val Marie, Saskatchewan.

Science Instructor for 200-bed General Hospital. School of Nursing, September classes only. 40-hr. wk., 1 mo. annual vacation, 10 statutory holidays. 1½ days sick leave per mo. cumulative. Apply Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

Registered Nurses for charge duty. Starting salary: $250 per mo., increase of $5.00 every 6 mo. to max. of $275. Evening & night duty $10 per mo. extra. 40-hr. wk. 2 wk. paid vacation after 1 yr. 6 paid holidays. Meals while on duty. Nurses' home completely furnished, including linen & laundry available for $30 per mo. Apply County Memorial Hospital, Gooding, Idaho.

Registered General Duty Nurses for 118-bed General Hospital along the shores of Lake Michigan, 25 mi. from Chicago. Base salary: $300. Additional differential of $30 for evenings & $20 for nights. 5 day wk. Good personnel policies. Apply Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Ill.

Registered Nurses for Medical-Surgical, Psychiatric, Obstetrical & Pediatric Units, 325-bed, air-conditioned hospital. Starting salary: $265 with bonus for evening & night duty. 40-hr. wk. Liberal personnel policies, low cost cafeteria, free laundry. Apply Director of Nursing, Menorah Medical Center, 4949 Rockhill Rd., Kansas City, Missouri.

Registered Nurses for staff nursing in new & beautifully equipped 100-bed hospital in the Pacific northwest. Only 6 mi. from the Pacific Ocean. Delightful climate. Beginning salary: $290 for 40-hr. wk., $10 additional for p.m. & night duty. Apply Director of Nurses, County General Hospital, Tillamook, Oregon.

Registered Nurses for General Duty Staff. Salary commences at £40-10-0 per mo. with full maintenance. Transportation allowance. For full particulars apply Matron, King Edward VII Memorial Hospital, Bermuda.

Registered Nurses. Excellent opportunities in **Private Nursing** are available in Bermuda. Rates similar to those in effect in Province of Quebec. For information regarding openings write to Matron, King Edward VII Memorial Hospital, Bermuda.

General Duty Nurses for 16-bed hospital 25 mi. from Edmonton catering to medical & minor surgical cases. Starting salary: $230 per mo. with perquisites of $22.50. Usual increments. 1 mo. vacation after 1 yr. service. Please state training, experience, date available & any other pertinent data in application. Apply c/o B. D. Stover, Sec.-Manager, Civic Hospital, Devon, Alberta.

General Duty Nurse for 17-bed hospital. Starting salary: $200 gross. 1 mo. vacation with pay after 1 yr. service. $5.00 per mo. increase after each 6 mo. service up to 3 increases. Transportation refunded after 6 mo. service. Apply Municipal Hospital, Elnora, Alberta.

General Duty Nurses, $230-$250, **Operating Room Nurse,** $250-$270 including increments. 40-hr. wk. 28 days vacation & 1½ days sick leave monthly. Room & full board $25 per mo. Fare from Vancouver refunded after 6 mo. service. Apply Matron, St. George's Hospital, Alert Bay, B.C.

General Duty Nurses. Salary: $230-270, $10 increment for experience. 40-hr. wk. 1½ days sick leave per mo. cumulative; 10 statutory holidays, 1 mo. vacation. Must be eligible for B.C. registration. Apply Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

General Duty Nurses for 430-bed hospital; 40 hr. wk. Statutory holidays. Salary $240-$273. Credit for past experience. Annual increments; cumulative sick leave; 28 days annual vacation; B.C. registration required. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

General Duty Nurses for 100-bed hospital in north coast city. Salary: $273 per mo. with 3 yearly increments of $10. Excellent living accommodation $40. Good personnel policies. Apply Supt. of Nurses, Prince Rupert General Hospital, Prince Rupert, B.C.

Royal Jubilee Hospital, Victoria, B.C. invites applications for **General Duty Nurses** for permanent positions & vacation relief in 500-bed General Hospital. Salary $227.50-$262.50 5-day, 40-hr. wk. 4-wk vacation. 10 statutory holidays. Pension plan. Attractive employee benefits. Apply, Director of Nursing.

General Duty Nurse: The Blanchard-Fraser Memorial Hospital (71-bed) located in Kentville, Nova Scotia, offers a General Duty Nurse ideal working conditions. 1 mo. annual vacation, excellent personnel policies plus modern living quarters with full maintenance in new nurses' residence. For further information apply to Superintendent of Nurses.

General Duty Nurses for 65-bed hospital. Gross salary: $185-$210. 44-hr. wk. Statutory holidays. For further information apply Director of Nursing Services, General & Marine Hospital, Collingwood, Ont.

An Opportunity for

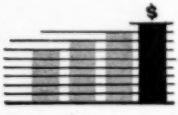
50 NURSES

in Hamilton, Ontario!

The three city-owned hospitals, the General, the Mountain and the Nora-Frances Henderson, have recently undergone an expansion program and are in immediate need of a minimum of 50 Registered Nurses.

Recognized as one of the most modern-equipped hospitals in Canada, the Hamilton General offers the Registered Nurse working and recreational facilities second to none.

Situated in the heart of what has been termed the "Golden Horseshoe", Hamilton is a city practically equidistant to Toronto and Buffalo, big enough to be interesting, yet small enough to be friendly and hospitable to the individual.



The rates of pay to Registered Nurses are the highest in the Province of Ontario. For Registered Nurses who work rotating hours of service, the beginning salary is $53.00 per week. The daily rate is $10.50 for each eight-hour period of duty.

Hours of duty: (a) 8 hour day—42 hours weekly average—rotating service. DAYS: 7 a.m. to 3.30 p.m. or 10 a.m. to 7 p.m.; EVENINGS: 3 p.m. to 11.30 p.m.; NIGHTS: 11.15 p.m. to 7.15 a.m. These schedules include one half hour for each meal and 15 minutes for morning coffee. (b) Two days off three successive weeks and one day off every fourth week. (c) All statutory holidays or compensatory time.

Vacations: Registered Nurses after one year of service receive 3 weeks vacation with pay. It is less than 200 miles to the beautiful Muskoka Lakes District, less than 2 hours to the U.S. border.

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Please send me more information concerning the opening for 50 nurses at your hospital. My address is:

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General Duty Nurses for Medical, Surgical, Pediatrics, Obstetrics. Good salary & personnel policies. Apply Director of Nursing, Victoria Hospital, London, Ont.

General Duty Nurses for all departments. Gross salary: $210 per mo. if registered in Ontario $200 per mo. until registration has been established. $20 per mo. bonus for evening or night duty; annual increment of $10 per mo. for 3 yrs. 44-hr. wk., 8 statutory holidays, 21 days vacation & 14 days leave for illness with pay after 1 yr. of employment. Apply: Director of Nursing, General Hospital, Oshawa, Ont.

General Duty Nurses (2) for new 173-bed hospital. Good personnel policies. Starting salary: $215 per mo. 44-hr. wk. Apply Director of Nurses, Plummer Memorial Public Hospital, Sault Ste. Marie, Ontario.

General Duty Nurses for 60-bed General Hospital. Good salary & personnel policies 44-hr wk. All statutory holidays. Sick leave allowance. Apply Supt., Public Hospital, Smiths Falls, Ontario.

General Duty Nurses (2) for 20-bed modern hospital. Salary: $200 per mo. plus full maintenance. Usual holidays with pay, sick leave etc. Fare refunded one way after 1 yr. Separate modern nurses' home. Apply Matron, Union Hospital, Vanguard, Sask.

General Duty Nurses for 650-bed teaching hospital in central California. Salary: $303-$356 per mo. 40-hr. wk. Liberal vacation, holiday & sick leave plan. Apply Personnel Office, 510 E. Market St., Stockton, California.

General Staff Nurses for 400-bed Medical & Surgical Sanatorium, fully approved student affiliation & postgraduate program. Full maintenance. Recreational facilities. Vacation with pay. Sick benefits after 1 yr. Blue Cross coverage. Attractive salary; 40-hr. wk. For further particulars apply Supt. of Nurses, Nova Scotia Sanatorium, Kentville, N.S.

Staff Nurses for 600-bed General & Tuberculosis Hospitals with student programs. In central valley, city of 108,000. State & Junior Colleges afford opportunity for advanced education. Salary $300 with 4 annual increases to $341. Full maintenance $45 per mo. Liberal personnel policies. Apply Assoc. Director of Nursing Service, County General Hospital, Fresno, California.

General Staff Nurses (Men & Women). for well equipped 400-bed General Hospital. An opportunity to learn nursing team leadership. Monthly salaries: $310-$350 plus differential of $30 monthly for evenings or nights. Attractive individual roms available, $20-$25 per mo. Convenient transportation to colleges & close by famous loop. Write to Dept. CNJ, Mount Sinai Hospital Medical Center, 2750 West, 15th Place, Chicago 8, Illinois.

Staff Nurses for 500-bed General Hospital. Beginning salary: $300 per mo. with advancement to $335 for those eligible for registration in the state of Michigan. Additional differential $1.50 per afternoon or night. 40-hr. wk. Hospital & school of nursing fully approved. Apply Director of Nursing, The Grace Hospital, 4160 John R. St., Detroit 1, Michigan.

General Duty Staff Nurses for 185-bed General Hospital. School of nursing. Basic salary: days, $265, evening & night shifts, $275. 40-hr. wk. Annual vacation, 6 paid holidays. Sick leave, 12-days per yr. Write to Director of Nursing Service, St. Vincent Hospital, Billings, Montana.

Staff Nurses for 225-bed General Hospital, on outskirts of New York City. Salary: $240-$280. $30 for permanent evening duty, $25 for permanent night duty. Apply Director of Nursing, St. John's Riverside Hospital, Yonkers, N.Y.

Graduate Nurses (4) for permanent staff Municipal Hospital. Net salary $180 per mo. with full maintenance. At the end of each 6-mo. period on staff Graduate nurses will receive a bonus of $120 thus making the net salary in effect $200 per mo. before income tax. 2 day vacation time is earned each full mo. worked, 8 statutory holidays in addition. Liberal sick pay & free hospitalization included in plan. We have a very nice residence for the nursing staff & are only 2 hrs. from Calgary by Trans-Canada highway or C.P.R. main line. You will like it here. Apply Matron, Municipal Hospital, Bassano, Alta.

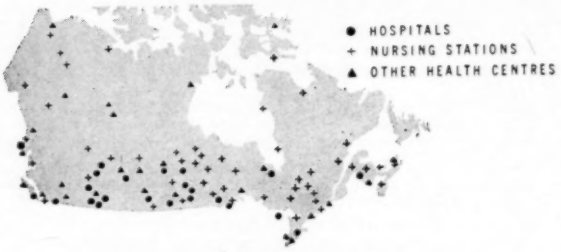
Assistant Graduate Nurse (Immediately) for the Wainwright Clinic. Please state qualifications & salary expected. Apply to Drawer 899, Wainwright, Alberta.

Graduate Nurses (3) for 24-bed hospital. Salary: $230 per mo. if B.C. registered; less $40 board, lodging, laundry. 1 mo. vacation after 1 yr. on full pay. 1½ days sick leave per mo. cumulative. Apply, stating experience to Matron, Terrace & District Hospital, Terrace, British Columbia.

Graduate Nurses for full time positions in 91-bed General Hospital in central B.C. Expanding community with new hospital planned. Salary: $235 per mo. depending on experience. 28-days annual vacation. Liberal sick leave allowance & other perquisites. Room & board available for nominal charge. Transportation refunded after 6 mos. Apply Director of Nursing, Prince George & District Hospital, Prince George, B.C.

Graduate Nurses (General Staff Positions) for General Hospital. Salary: $239. per mo. as minimum & $277.25 as maximum, plus shift differential for evening & night duty. 40-hr. wk. Temporary residence accommodation is available. Applicants not registered in B.C. should forward a letter of acceptance of registration in B.C. from the Registrar of Nurses, 2524 Cypress St., Vancouver, B.C. Please apply Personnel Dept., Vancouver General Hospital, Vancouver, B.C.

NURSING WITH INDIAN AND NORTHERN HEALTH SERVICES



OPPORTUNITIES FOR REGISTERED HOSPITAL NURSES, PUBLIC HEALTH NURSES, and NURSING ASSISTANTS or PRACTICAL NURSES

for Hospital Positions and Public Health Positions in Outpost Nursing Stations, Health Centres and Field Positions in the Provinces, Eastern Arctic and North-West Territories.

SALARIES

(1) Public Health Nursing Supervisors: up to $4,620 depending on qualifications and location.

(2) Directors of Nursing in Hospitals: up to $4,620 depending on qualifications and location.

(3) Public Health Staff Nurses: up to $3,600 per year depending on qualifications and location.

(4) Hospital Staff Nurses: up to $3,420 per year depending upon qualifications and location.

(5) Nursing Assistants or Practical Nurses: up to $185 per month depending upon qualifications and location.

• Room and board in hospitals — $30 per month. Statutory holidays. Three weeks' annual leave with pay. Generous sick leave credits. Hospital-medical and superannuation plans available.

• Special compensatory leave for those posted to isolated areas.

For interesting, challenging, satisfying work, apply to — Indian and Northern Health Services at one of the following addresses:

(1) Regional Superintendent, 4824 Fraser Street, Vancouver 10, B.C.

(2) Regional Superintendent, c/o Charles Camsell Indian Hospital, Edmonton, Alberta.

(3) Regional Superintendent, 735 New Federal Building, Regina, Saskatchewan.

(4) Regional Superintendent, 522 Dominion Public Building, Winnipeg 1, Manitoba.

(5) Zone Supervisor of Nursing, Box 292, North Bay, Ontario.

(6) Zone Supervisor of Nursing, P.O. Box 3427, St. Roch Branch, Quebec, Que.

(7) Moose Factory Indian Hospital, Moose Factory, Ontario.

or

Chief, Personnel Division, Department of National Health and Welfare, Ottawa, Ontario.

Graduate Nurses for new, very modern 88-bed hospital in a pleasant progressive town. Nurses salary: $200 per mo. Annual increase $10 per mo. for 3 yrs. 2-wk. shift rotation, bonus for night shifts. 1 hr. drive to Toronto & several resorts. Local swimming pool, bowling alleys, skating, theatres etc. Apply Director of Nurses, Dufferin Area Hospital, Orangeville, Ont.

Graduate Nurses for duty on Obstetrical, Medical & Surgical Wards. Personnel policies as recommended by the Assoc. of Nurses of the Prov. of Quebec. Please apply Director of Nursing, Queen Elizabeth Hospital of Montreal, 2100 Marlowe Ave., Montreal 28, Que.

Graduate Nurses for general staff duty in a tuberculosis hospital for treatment of adult medical patients. For further information, apply to Director of Nursing, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, P.Q.

Supervisor (qualified.) Good salary. Extra allowance for experience if French speaking. 5-day wk., 4-wk. vacation, 18 days sick leave cumulative annually. Car is provided. Half cost of uniform is allowed & half of Blue Cross. Workmen's Compensation. Good working conditions. Apply Sec.-Treas., Porcupine Health Unit, 164 Algonquin Blvd. E., Timmins, Ont.

Public Health Nurse Grade 1. British Columbia Civil Service, Dept. of Health & Welfare. Starting Salary $255, $260, $266 per mo., depending on experience, rising to $298. per mo. Promotional opportunities available. Qualifications: Candidate must be eligible for registration in British Columbia & have completed a University degree or Certificate course in Public Health Nursing. (Successful candidates may be required to serve in any part of the Province.) Cars are provided. 5-day wk. in most districts. Uniform allowance. Candidates must be British subjects; preference is given to ex-service women. Application forms obtainable from all Government Agencies, the Civil Service Commission, 544 Michigan St., Victoria, or 411 Dunsmuir St., Vancouver 3, to be completed & returned to the Chairman, Civil Service Commission, Victoria. Further information may be obtained from the Director, Public Health Nursing, Dept. of Health & Welfare, Parliament Bldgs., Victoria, B.C.

Public Health Nurses for generalized program in Seaway Development Area. Minimum salary: $2,800 with allowance for experience. Group insurance & Blue Cross available. Good transportation policy. Apply R. S. Peat, M.D., Medical Officer of Health, S. D. & G. Health Unit, 104 Second St. W., Cornwall, Ont.

Public Health Nurse (1) for generalized program in rural & semi-urban area adjacent to metropolitan Toronto. Excellent working conditions including pension plan, group ins. & transportation arrangements. Apply Dr. R. M. King, York County Health Unit, Newmarket, Ont.

Public Health Nurses (2) for generalized program in city of 43,000. Blue Cross & P.S.I. employer shared. Transferrable accumulative sick leave & pension plans. Workmen's Compensation. Group insurance available. Transportation provided or allowance — 10¢ first 2,000 mi., 8¢ per mi. thereafter. 5-day wk. 1 mo. vacation with extra time at Christmas. Salary scale: $3,000 for inexperienced nurses to start with annual increments of $150. All starting salaries dependent on experience. For further information please write supplying details of training & experience to Medical Officer of Health, City Hall, Peterborough, Ontario.

Public Health Nurses (qualified.) Salary: $3,100 depending on dist. served, less if in the Timmins area. Annual increment $150 per annum for 4 yrs. Additional allowance for experience & if French-speaking. 5-day wk. 4-wk. vacation, 18 days sick leave annually (cumulative). Car is provided. Half cost of uniform is allowed & half of Blue Cross. Workmen's Compensation. Good working conditions. Apply Sec.-Treas., Porcupine Health Unit, 164 Algonquin Blvd. E., Timmins, Ont.

Public Health Nurses (Qualified) for a generalized program in Etobicoke Township (suburb of Toronto). Minimum salary: $3,200. Annual increments to $3,680. Starting salary based on experience. Car allowance $670 per annum. 4 wk. vacation after 1 yr. Blue Cross & Pension Plan. Apply Director of Public Health, Nursing, Township of Etobicoke 4946 Dundas St. W., Toronto 18, Ont.

Matron for 23-bed hospital (Immediately). Salary: $270-$295. We have 2 doctors & full complement of nurses. Good farming area. Green Water Lake summer resort nearby. Please state experience & apply P. Tomyn, Sec.-Manager, Union Hospital, Kelvington, Sask.

Registered General Duty Nurses for 18-bed active hospital. Good salary. 44-hr. wk. 3-wk. vacation, statutory holidays & sick leave benefits. Apply administrator, District Hospital, Shelburne, Ont.

Graduate General Duty Nurses for 52-bed hospital situated on main line between Edmonton & Calgary. Salary: $236 gross less $26 maintenance. 3 increments after 6 mo. 1 yr. & 2 yr. service. 1 mo. vacation after 1 yr. service. Please apply to Mrs. J. Harvie, Matron, Municipal Hospital, Lacombe, Alta.

Dietitian for completely new 250-bed hospital. 70-student school of nursing. For further information please apply to Administrator, Hotel Dieu Hospital, Cornwall, Ontario.

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Requires the following personnel immediately:

Assistant Educational Director

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Excellent salary & personnel policies.

1 class a year admitted to school.

New modern teaching unit.

800-bed hospital.

APPLY TO: DIRECTOR OF NURSING

NURSES — REGISTERED CALIFORNIA

For General Duty for beautiful new 112-bed modern hospital just opened. Advancement to Supervisory positions for early applicants. Salary: $310 to begin, $320 for evening & night shifts. Merit increases, 40-hr. wk., annual vacation & holidays with pay. Sick leave, hospitalization insurance provided. Dynamic, lovely California city in beautiful San Joaquin Valley, 2 hr. from Los Angeles. Transportation costs to California will be reimbursed to applicants after 1 yr. Nurses needed immediately, early applicants & first arrivals will receive premium attention. Housing available.

Send full particulars immediately to:

DIRECTOR OF NURSES,
GREATER BAKERSFIELD MEMORIAL HOSPITAL,
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Calling All Canadian Graduate Nurses

- **How would you like to work and live in the heart of Manhattan?**

  THE ROOSEVELT HOSPITAL, a voluntary, general hospital, offers you this opportunity.

- **Why not enjoy these benefits offered by Roosevelt?**

  BASE SALARY — Begins at $270 per month, without experience. Experience qualifies for higher starting salary.

  INCREMENTS — Start after first 6 months and continue annually.

  BONUSES — $40 for evening and $20 for night duty.

  VACATION — 4 weeks annually.

  HOLIDAYS — 10 annually.

  LAUNDRY SERVICE

  HOSPITALIZATION

  HEALTH SERVICE

  SOCIAL SECURITY

For further information write to:

DIRECTOR OF NURSING,
DEPARTMENT NS,
ROOSEVELT HOSPITAL
59th Street West,
New York City

Matron (R.N.) for modern 12-bed hospital. Plans for additional 12-beds & new nurses' home in spring. Starting salary: $250 per mo. with full maintenance. Annual increment $10 per mo. to $280. **Registered Nurse (1),** starting salary: $180 with full maintenance. Annual increment of $10 per mo. to $210. 3-wk. vacation with pay after 1 yr. service, 4-wk. thereafter. Apply Mrs. N. E. Parkinson, R.N., Matron, District Hospital, Shoal Lake, Man.

Supervisor, starting salary: $245 (must be registered in Sask.). **Charge Nurses,** starting salary: $235. **General Duty Nurses,** salary: $220. 6 increments of $5.00 per mo. every 6 mo. 28-day vacation plus 9 statutory holidays. Full maintenance, $30 per mo. if desired. Apply Director of Nursing, Victoria Hospital, Prince Albert, Sask.

Nursing Instructor responsible for affiliation program in Tuberculosis nursing. Applicants should state qualifications, experience, age, marital status & salary expected. Attractive suite available in modern nurses' residence. For further information apply Director of Nursing, Essex County Sanatorium, Windsor, Ontario.

Registered Nurses (2) for active 16-bed hospital. Salary: $200 plus full maintenance. 4, $5.00 increases at 6-mo. intervals. 3-wk. annual vacation, all statutory holidays. 1½ days sick leave allowed per mo. cumulative to 30 days. Send applications or requests for further information to Miss A. N. Routledge, Matron, Municipal Hospital, Glendon, Alta.

Registered General Duty Nurses (2) for modern 35-bed hospital 80 mi. east of Edmonton. Salary: $217.50 less $25 maintenance. 4 semi-annual increases of $5.00. 44-hr. wk. 1 mo. vacation with pay after 1 yr. service. Sick leave benefits. Apply Mrs. S. Brower, Matron, Municipal Hospital, Viking, Alta.

Registered Nurses or Graduate Nurses (2) for fully modern 30-bed hospital. Gross starting salary: $210 & $200 per mo. respectively less $25 for full maintenance. Salary increased according to experience. Overtime. $5.00 increment after each 6 -mo. service. 44-hr. wk. 4-wk. vacation with pay after 1 yr. service. All statutory holidays. Accumulative sick leave. Separate living quarters. Apply Supt., District Hospital, Roblin, Manitoba.

Registered Nurses (2) for 60-bed hospital. Salary: $180 plus full maintenance. Increment after 1 yr. service for 4 yrs. 8-hr. duty. 28 days vacation. Residence accommodation. Apply Supt. of Nurses, Alexandra General & Marine Hospital, Goderich, Ont.

Public Health Nurses (Qualified) for generalized public health nursing service. Salary range: $3,284-$3,729. Starting salary based on experience. Annual increments. 5-day wk. Vacation. Shared hospitalization, sick pay & pension plan benefits. Apply Personnel Dept., Room 320, City Hall, Toronto, Ont.

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New Rochelle, New York

A Voluntary, general hospital of 306 beds. Located in Westchester County, adjoining New York City.

BASE SALARY—Begins at $275. in cash per month, plus 2 meals and laundry.

INCREMENTS—$5.00 every six months for a period of four years.

PREMIUM—$25. for evening and for night duty.

VACATION—2 weeks first year; 3 weeks second year; 4 weeks thereafter.

HOLIDAYS—8 annually.

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LOCATION—20 miles from New York City—on Long Island Sound. Train service every half hour to and from the City.

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NEW ROCHELLLE HOSPITAL
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Personnel policies as recommended by A.N.P.Q.

Apply: **DIRECTOR OF NURSING, 2100 Marlowe Ave., Montreal 28, Que.**

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General Staff Nurses for Medical, Surgical, Obstetrical and Pediatric Services. Forty hour week. Salary $220 to $260 gross per month. Differential for evening and night duty, Residence Accommodation if desired.

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DIRECTOR OF NURSING, UNIVERSITY HOSPITAL,
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Personnel Practices Provide:

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- Retirement annuity benefits.

For further information write to:

Director in Chief,
Victorian Order of Nurses for Canada,
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New 87-bed hospital for Chronically Ill

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New 165-bed Home for the Aged

Salary according to specifications & experience.

Apply: Mr. S. Ruth, Administrator, Jewish Home for the Aged,
3560 Bathurst St., Toronto 12, Ontario

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NEWFOUNDLAND

Association of Registered Nurses

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QUEBEC

The Association of Nurses of the Province of Quebec

The Association of Nurses of the Province of Quebec, created by Licensing Act, April 17, 1946, replacing The Registered Nurses Association of the Province of Quebec Incorporated February 14, 1920.

Pres., Mlle Eve M. Merleau, 3201 ave Forest Hill, Montréal; Vice-Pres., *(Eng.),* Sr. M. Felicitas, Miss E. Geiger; *(Fr.),* Mlles F. Verret, L. Couet; *Hon. Sec.,* Sr. J. Forest; Hon. Treas., Miss M. M. Wheeler; *Councillors:* Mlles L. Lapointe *(Dist. 1),* R. Aubin *(Dist. 3),* Marie-Jeanne Clairmont *(Dist. 5),* A. Mailloux *(Dist. 7),* G. Lamarre *(Dist. 9).* The above constitute the *Executive Council* and are *Members of the Committee of Management, together with:* Mlles G. Gosselin, M. Gauthier, M. Jalbert, A. Girard, J. Reynolds, J. Ouimet, Misses G. Purcell, A. Christie, Mmes R. M. Duhaime, J. Morency, Srs. St-François-Xavier, Barcelo. *Advisory Committee:* Misses R. Chittick, J. Radley-Walters, C. Aitkenhead, E. C. Flanagan, C. V. Barrett, H. Lamont, Mlles A. Martineau, J. Gagnon, S. Pilon, Srs. Valérie de la Sagesse, St-Ferdinand, D. Lefebvre. *Committee Chairmen: Nursing Education,* Sr. D. Lefebvre, Miss H. Lamont; *Nursing Service,* Miss G. Purcell, Mlle G. D. Côté. *Chairmen, Board of Examiners (Eng.),* Miss A. Haggart, Royal Victoria Hosp., Montréal; *(Fr.),* Mlle J. Trudel, Hôpital Ste-Justine, Montréal. **Sec.-Registrar, Miss A. Winonah Lindsay. Visitor to French Schools of Nursing, Mlle Suzanne Giroux. Association Headquarters, 1538 Sherbrooke St. W., Montréal 25.**

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Saskatchewan Registered Nurses' Association (Incorporated 1917)

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Alumnae Associations

ALBERTA

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University of Alberta, Edmonton

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MANITOBA

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Grace Hospital, Winnipeg

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NEW BRUNSWICK

Victoria Public Hospital, Fredericton

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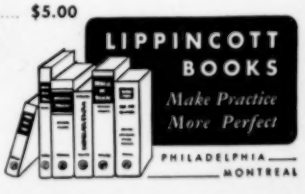
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